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ABSTRACT

Although many California children are growing up in circumstances favoring school performance, many others are inhibited by poor health, poverty, low-quality child care, and other factors external to schools. This report assembles a set of indicators depicting California children's quality of life. Data are included on physical and mental health, physical safety, sexual behavior, and academic achievement. The report also evaluates adult-controlled children's settings--families, day care facilities, schools, and neighborhoods--and addresses the systems serving children, such as health and welfare services, justice systems, and private organizations. The size, composition, and trends of California's changing population are emphasized throughout the report. There is a growing disparity, largely along racial/ethnic lines, between advantaged and disadvantaged children. Since 1980, the income gap between the poorest and "other" families has increased. There is great inconsistency in the quality of publicly financed, insititutional child care. Also, California lacks a systematic means of gathering data about children's well-being and of establishing, coordinating, and evaluating programs designed to meet children's needs, particularly preschoolers. Except for schooling, child care, and some preventive health programs, most state policy is directed at children with manifest and severe problems. From the 1940s to the 1970s, California led the nation in its commitment to serving children's needs. That leadership has faded over the past decade. The new problems facing children reflect the changing family structure, the impact of immigration, and the emergence of a small group of very disadvantaged parents whose children are at great risk of inadequate physical, emotional, academic, and social development. Appendices and numerous chapter references are included. (MLH)

Policy Analysis for California Education (PACE)

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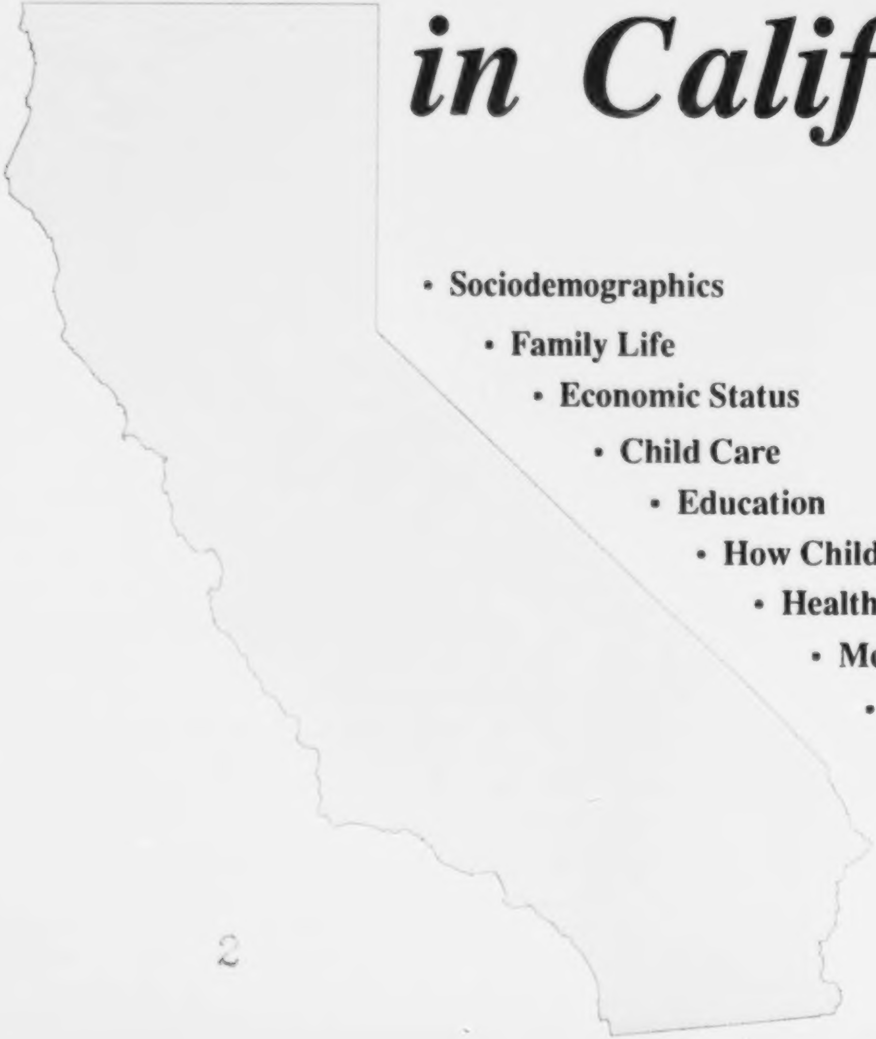
Conditions of Children in California



- Sociodemographics
- Family Life
- Economic Status
- Child Care
- Education
- How Children Spend Their Time
- Health
- Mental Health
- Child Abuse and Child Welfare Services
- Juveniles, Delinquency, and the Law
- Income Support Programs
- Policies for Children with Multiple Needs
- State Policy Making for Children

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Policy Analysis for California Education (PACE)

Conditions of Children in California

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Policy Analysis for California Education

Policy Analysis for California Education, PACE, is a university-based research center focusing on issues of state educational policy and practice. PACE is located in the Schools of Education at the University of California, Berkeley and Stanford University. It is funded by the William and Flora Hewlett Foundation and directed jointly by James W. Guthrie and Michael W. Kirst. PACE operates satellite centers in Sacramento and Southern California. These are directed by Gerald C. Hayward (Sacramento) and Allan R. Odden (University of Southern California).

PACE efforts center on five tasks: (1) collecting and distributing objective information about the conditions of education in California, (2) analyzing state educational policy issues and the policy environment, (3) evaluating school reforms and state educational practices, (4) providing technical support to policy makers, and (5) facilitating discussion of educational issues.

The PACE research agenda is developed in consultation with public officials and staff. In this way, PACE endeavors to address policy issues of immediate concern and to fill the short-term needs of decision makers for information and analysis.

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The concept of a Conditions of Children report was an outgrowth of PACE's prior work on the Conditions of Education. PACE produced comprehensive reports on the Conditions of Education from 1984 to 1988, and with each annual update became more concerned about the profound impact of environmental factors outside classrooms upon educational attainment. Many California children are growing up in circumstances that help their school performance, but many are inhibited by poor health, poverty, quality of child care, and other factors external to schools. We decided that an improved analysis of education must be embedded in the overall context of children. We hoped to answer one question: What is it like to be a child in California?

Ted Lobman, Vice President of the Stuart Foundations arranged for us to meet with a group of children's experts in the San Francisco Bay Area. A group from the San Francisco Health Policy Institute at the University of California was particularly helpful in enabling us to understand more about how children's conditions interact and the scope necessary to do this type of report. A planning grant was obtained from the James Irvine Foundation to conceptualize a study and recruit potential authors. We continued to meet with an informal steering committee throughout 1986 and by 1987 had a clear plan in mind.

In 1986 and 1987 the authors were convened several times to outline the chapters, themes, and develop the focus. In April 1987 grants to implement the study were secured from the James Irvine and Stuart Foundations. Their generous support has been crucial to this enterprise, and the staffs of Irvine and Stuart have given much useful advice.

The initial concept was to allow each author to prepare a chapter in his or her area of expertise. These chapters were distributed for external review to experts around the nation. The authors acknowledge these reviewers in their chapters, but the project director also used some overall advisers, including Jim Peterson of Child Trends Inc. (Washington, D.C.), Hal Richman of the University of Chicago School of Social Work, Philip Lee of the University of California, San Francisco, and Neal Halfon of Oakland Children's Hospital.

An initial compilation and summary of all the chapters was reviewed by a Task Force of California Children's policymakers convened by State Superintendent of Schools Bill Honig, Assemblyman John Vasconcellos, and Senator Rebecca Morgan. This group played a particularly active role in finding major gaps in the report. Subsequent sections on mental health and immigration were commissioned as a result of their efforts, and several parts of the report were expanded, including the chapter on Children, Violence, and the Law.

In the Spring of 1988, Michael Wald of the Stanford Law School agreed to play a major role in reviewing and editing the entire document. Only someone with Wald's broad experience in children's policy could have completed such an encompassing task. While he entered rather late in the process, he was able to rethink, expand, or eliminate parts of the report. His detailed editing role, however, was reduced by his interests in increasing the scope of chapters 1–4, and writing the introduction. However, he was able to comment critically and in detail on each chapter, which led to another round of changes by the chapter authors.

Final copy editing, layout, and production were provided by the PACE staff at the University of California, Berkeley, in particular, Julia Koppich (PACE Associate Director) and Linda Humphrey (PACE Publications Coordinator). They were assisted by Linda Purrington, a freelance copyeditor. We also received sound advice on format and media presentation from the staff of *Children Now*, particularly Jim Steyer and Wendy Lazarus. The four PACE directors– Michael Kirst, James Guthrie, Allan Odden, and Gerald Hayward– reviewed the report chapters and developed some of the major cross-cutting themes.

Marc Ventresca and Claire Smrekar were part of a Stanford planning and strategy team throughout the entire process. While each of these advanced graduate students authored chapters, they were integral to all aspects of the research process. Glen Gilbert, a graduate student in Stanford's Graduate School of Education assisted with research and editing. Laura Walkush, a Stanford undergraduate, provided research analysis and initial formatting of several charts. Suzanne Herko and Cliff Rachlin, also Stanford undergraduates, provided useful data collection and analysis. Eve Dimon of the Stanford staff assisted in all phases of report preparation.

We wish to thank all of those who helped and gave us advice. Many were not compensated for this work, and the individual authors spent much more time than they had originally expected.

This is the first edition of what we hope will be a periodic analysis of the Conditions of Children in California. We expect to spend some time in the near future filling the data gaps Michael Wald mentions in his Introduction. The 1990 Census data will provide a valuable inflow of new data, and when combined with this 1989 *Conditions of Children*, should provide enhanced trend analysis. Thus, we hope to produce a second edition of this report in 1993.

Finally, all views expressed are those of the authors, and do not necessarily reflect the views of the institutions of which they are a part.

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February 1989

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Sources of Data

As we note throughout this report, systematic longitudinal data based on representative samples of children for California and the United States are virtually nonexistent. Instead, we rely on a variety of sources for the data in this report. These data may be based on complete counts, administrative records, sample surveys, estimates, and unpublished data. The collecting agencies include federal and state statistical agencies, federal and state regulatory agencies, private research agencies, and private organizations. Consequently, the data vary considerably as to reference periods, methods of collection, definitions of terms, and, for continuing series, number and frequency of time periods for which data are available. Also, all the data are subject to errors of various kinds, some due to the sponsoring or collecting agencies, others due to collection and processing methods. Even censuses and surveys which attempt to cover a "complete" population are subject to response errors, processing and tabulation errors, and disagreements as to the meaning of the data.

In compiling this report, we necessarily draw on data that differ in survey procedures, population and time references, and measurement instruments. These data may (1) count children at different times, even within the same year, and hence return different totals, (2) use definitions and criteria that may not be consistent between sources, and (3) select out for specific populations within the overall child population. Consequently, the results from the several sources are not strictly comparable.

Although we have attempted to minimize these differences, some variation in total counts remains. In the case of inconsistent terms or categories, we indicate this in tables and charts, and note it in the text. The most common of these are in the available data disaggregated by racial/ethnic categories (Chapter 2). For most population trends (population counts, fertility, and births), data are available only by general "race" categories—white, black, and other, and in recent years, by a "Hispanic" or "Spanish Origin" ethnic category that is a double count. These classifications are increasingly problematic for understanding the California population, as persons of Hispanic origin and of Asian or Pacific Islander descent comprise more and more significant portions of the population. In addition, the diversity within these groups themselves, as well as the presence of American Indian peoples—each with distinctive sociodemographic profiles—make it impossible to compare existing data sources with more recent and refined countings. Where possible, however, we have assembled data that distinguish non-Hispanic whites, blacks, and others from all Hispanics, and that disaggregate the "other" category into some of its component groups. Despite the possible confusion that may result, we believe that the benefits of reporting these more detailed data outweigh the disadvantages.

Another general area of variation rests with the counting of children in households and families of various types. Some sources use counts of all children, some of all children in households or particular family arrangements, and some of only "own" children (that is, children of the householder or householder spouse but not other relatives or nonrelatives). Similarly, in counts of households, some sources report data on households with single female (or male) householders, while others report only those with single mother (or father) householders.

Bureau of the Census and the Current Population Surveys

In the chapters describing trends in the California child population, we primarily use data from the U.S. Decennial Censuses and from the Current Population Surveys and Supplements (CPS). We especially rely on the CPS for data for intercensal years.

The CPS is a monthly survey conducted by the Census Bureau primarily to update the decennial population estimates and to provide data for the Department of Labor employment reports. Each March, the survey gathers a broad array of social, demographic, and economic data from a probability sample of U.S. households. Since the CPS is a national sample, it is not specifically intended for state-by-state breakdowns. However, because the sample size and characteristics for large states like California are satisfactory for many purposes, such a special analysis is possible, even though the Census Bureau does not provide for it.

The CPS survey files are hierarchical, containing data organized around households as the highest unit of analysis. A household record contains information about the household as a whole. One or more family records follow for each family living in the household. Within each family, a personal record is constructed for each family member. For the present analyses, children were defined as the unit of analysis of interest. A rectangular, nonhierarchical file was produced containing one record for each child up through age 17 in the sample. Each specially constructed child record brings together information from the child's own personal record, from the personal records of the child's mother and father in the household (if present), from the family record of the family of which the child is a member, and from the household record.

Collapsing the Data

To increase the sample sizes of the cells on which population estimates at the state level are based, thus improving the reliability of the estimates, data from adjacent years (1980–81 and 1985–86) were combined. In this report, the population estimates are simple averages of the weighted population estimates, based on the two-year total of the unweighted (that is, sample) numbers of the combined years. These may be interpreted as the population estimates approximately halfway between the two data collection points (September 1980 and 1985, respectively). This time reference is only approximate, however, as no attempt was made to adjust for population change curves.

Statistical Significance

In our analysis and discussion of these data, no tests of statistical significance have been carried out. In most cases, the sample sizes are large enough to make any differences of practical consequence statistically significant, and for the most part we have limited our focus to differences of that magnitude.

Two Final Notes on Data Sources

We have attempted to provide detailed references for those who might wish to go directly to the data source. Where the reference is simply to an agency, the information was obtained directly from an individual in that agency.

We are especially indebted to Dr. James Peterson, Assistant Director of Child Trends, Inc., for his invaluable advice and assistance in the development of the special CPS tabulations, and to the Scientific Applications Programming Staff in the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, who carried out the actual programming and data production.

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Chapter 1
Introduction
Michael S. Wald

- This report is an attempt to assemble a set of social indicators that suggest an overall portrait of the quality of life of California's children. It synthesizes material not readily available to policymakers, points out gaps in available data, and where appropriate, offers limited policy recommendations.
- Data are included on physical and mental health, physical safety, sexual behavior, and academic achievement. Because children are largely dependent upon settings and services controlled by adults, the report also attempts to evaluate the conditions of the settings in which children develop– families, day care facilities, schools, and neighborhoods– and addresses the systems that serve children, such as health and welfare services, justice systems, and private organizations.
- Recent polls indicate that three out of four American adults feel that problems facing children are worse today than in decades past. Most think that parents and the schools are not doing a satisfactory job of child-rearing. Moreover, the chief executives of 225 American corporations have expressed concern about the likelihood of "an expanding educational underclass."
- In spite of these perceptions, it is clear that most children in the nation and in California are healthier, wealthier, and better schooled than were their earlier counterparts. Is there really cause for concern? Is the condition of children better or worse? Or both?
- The size, composition, and trends of California's changing population are emphasized throughout the report. In the next ten years California will add one and a half million to the present population of seven million children, an increase of 20 percent. Children from ethnic or racial "minority" groups will constitute an increasing majority of California children.
- There is a growing disparity, largely along racial/ethnic lines, between advantaged and disadvantaged children. Though the economic well-being of most California children increased considerably in the decade before 1970, the gap in income between the poorest families with children and other families with children has grown in the past ten years.
- Inconsistency in the quality of publicly financed, institutional child care is another theme in this volume. In addition to a lack of qualitative uniformity, it appears that public systems that serve poor children are in worse condition than those that serve middle class or wealthy children.
- A final theme that emerges is that California lacks any systematic means of gathering data about children's well-being and of establishing, coordinating, and evaluating programs designed to meet children's needs. We know particularly little about the almost uncharted private sector of children's services, or about the lives of children between ages one and four.
- Except for schooling, child care, and some preventive health programs, most state policy is directed at children with manifest and severe problems. While there are good reasons to target programs at those most immediately in need, such programs commonly provide too little, too late really to improve the condition of children. Despite widespread recognition that a number of preventive programs are both cost efficient and best for children, such programs remain scarce.
- California appears to be in a period of retrenchment in its commitment to children. From the 1940s until the 1970s, this state exerted national leadership in developing attitudes toward children's needs, developing novel responses to the challenges of children's health care, day care, delinquency, abuse, and neglect. While California retains leadership in some areas, that leadership has faded over the past ten years. Despite the changing contexts in which children live, few new initiatives have been mounted on behalf of California's children.

- The new problems confronting California's children reflect the changing family structure, the impact of immigration, and the emergence of a small group of very disadvantaged parents whose children are at great risk of inadequate physical, emotional, academic, and social development. These new problems will require new policy initiatives, and perhaps new structures for the development of public policy. This report is intended to help guide policy-makers who would venture in these directions.

Chapter 2

A Sociodemographic Portrait

John W. Evans, Michael S. Wald, Claire Smrekar, Marc J. Ventresca, with Laura Walkush

- The well-being of California's huge child population is of increasing importance to the nation. At present, one in every nine American children is a Californian. Ten years from now, one in every eight children will live in this state.
- The child population in Los Angeles county alone totals more than two and one-quarter million persons—more than the child populations of over forty states and more than the *total* populations of twenty states. Los Angeles county is home to more than a third of the children in California.
- California's share of the nation's minority children is particularly large. One in every three Hispanic American children lives in California, and two in five Asian children live here. In ten years, half the children in the state will be Hispanic or Asian, with non-Hispanic whites comprising a shrinking proportion of the child population.
- The California children of the late 1970s, together with immigrant children, comprise a larger young cohort that will dramatically shift the numbers of children in particular age groups. In ten years, the youngest age groups may begin to decrease in size, even as the number of teenagers continues to increase for some time.
- Despite their burgeoning numbers, California's children comprise only one fourth of the state population, whereas they were one third of the population twenty years ago. Moreover, the percentage of households containing children is declining, due to some decline in the percentage who ever marry, some increase in the percentage of childless couples, and a change in the total age distribution.
- California's child population is so different from the nation's in size and ethnic diversity that federal social welfare policies are not optimally suited to this state.
- The well-being of children in this state depends increasingly upon the willingness of those without children to commit public and private resources to children. Failing this, the resources available to each child will decline.

Chapter 3

Family Life

Michael S. Wald, John W. Evans, Claire Smrekar, and Marc J. Ventresca

- Today's children live in more diverse family settings. Increases in divorce, in single mothers, and in alternative parenting arrangements have altered the traditional family lifestyle. There is evidence that divorce increases the risk that a child will experience problems in academic, emotional, and social development.
- Family conditions have a major impact on children's emotional well-being, and on their scholastic and social success. While the impact upon children of various family influences are complex, two salient factors emerge from the data as significant influences on a child's well-being: family structure and teenage parenthood.

- The average number of children in a household has declined. Seventy-seven percent of all families with children under 18 have one or two children; only 23 percent have three or more. Black, Hispanic, and Southeast Asian families tend to have more children than others.
- Although 75 percent of children live with two parents (including stepparents), 50 percent will live in a single-parent household sometime before the age of 18. The estimated average length of stay in a single-parent home will be six years.
- Major causes of changes in family structure are an increase in divorce and a rise in the numbers of births of children to single mothers.
- Divorce rates have doubled since 1960. One third of the children in California will experience parental divorce before age sixteen. Divorce is often attended by economic and psychological pressures that diminish the parent's supervision of children, and may thus contribute to school failure, drug and alcohol abuse, and early sexual activity.
- One in four California children is born to an unmarried mother. More than half of black children are born to single mothers.
- The income of single mothers is substantially lower than that of married parents. Almost half of all single mothers live at or below the poverty level.
- Despite widespread concern about the conditions of children born to teenage mothers, there is little research on the progress of these children. However, available evidence indicates that teenage parenthood is often detrimental to the parents and to their children.

Chapter 4

Economic Status

Michael S. Wald, John W. Evans, and Marc J. Ventresca

- The economic status of children depends on several factors: 1) family income, 2) number of children in the family, 3) proportion of family income spent by parents for their children, 4) amount society invests in children, and 5) amount of money children can earn from work.
- Between 1959 and 1969, the economic well-being of most children increased considerably. Since 1969, and especially since 1979, economic well-being of children has deteriorated.
- More than one in every five California children– 1.78 million children– lives in a family whose income is below the federal poverty level. Many more children live just slightly above the poverty line. The number of children living in poverty doubled between 1969 and 1987.
- In 1981, the proportion of children in poverty was lower in California than in the nation as a whole. By 1986, California's percentage of poor children was higher than the nation's. As a group children are worse off than adults– since 1969 there has been a greater percentage of children than adults living in poverty.
- The future number of children in poverty is likely to increase in California, largely as a result of increases in divorce, single parents, inadequate educational preparation, and low paying jobs for people reaching their child-bearing years.
- The income disparity between those children living in the poorest families and children living in other families has widened in the past 10 years.
- Poor families are disproportionately female-headed. Families headed by single mothers are four times more likely to be poor than are two-parent families. Three-fifths of female-headed

families with children under six are living in poverty. But poverty rates for children in California would have increased between 1969 and 1984 even without an increase in single-parent families.

- Working single mothers, most of whom do not receive child support from the father, earn wages lower than those of other women. Their wages generally are not high enough to raise them above the poverty level.
- Most California children (52%) in poverty live in two-parent families in which at least one parent works.
- For a family of four or more, in 1988, if *both* parents worked full-time at the minimum wage, their combined income still fell below the poverty line. Families with younger family heads, those under 30, and especially those under 25, are much more likely to be poor.
- Largely as a result of immigration, the face of California poverty differs from that of the nation as a whole. That face is far less black and far more Hispanic. And the family conditions of California's poor children are especially varied. Typically, the poor among California's Hispanic and Asian children live with two parents, poor white children live with a divorced mother, and poor black children live with a mother who never married. Hispanic poverty is primarily caused by low wages even if both parents work. White poverty comprises the largest subgroup of children in poverty nationally (44%), but only 26% in California.
- The children of the poor are three times more likely to die in infancy, four times more likely to become pregnant as teenagers, and are more likely to suffer serious illness, abuse, neglect, and to drop out of school than are their non-poor counterparts. Family income thus serves as a useful proxy for a child's well-being.
- Many poor children are not receiving the benefits of state and federal programs designed to help them. Though a greater proportion of poor children are covered by AFDC in California than in most states, still less than half of eligible families receive AFDC income. Moreover, a smaller percentage of poor children receives the benefits of food stamps, free school lunches and public housing in California than in the nation as a whole.
- Because the composition of California's poor differs from national norms, with so many California Hispanic and Asian poor, federal policies are not optimally suited to this state. Moreover, even state policies toward the poor may not take into account the great ethnic diversity. Most poor Hispanic families, for example, will not be assisted by increased welfare payments, but could move out of poverty through higher-paying jobs.

Chapter 5

Child Care and Early Childhood Programs

W. Norton Grubb

- Less than a third (28.6 percent) of California families have the father working full time and the mother at home. Approximately 1.14 million California children are in some type of child care, though only 15 percent are in child care centers. Many parents assemble patchwork arrangements, combining their work schedules and small amounts of care by relatives, so that their children need not be in formal child care. In families where both parents work, one-third have at least one part-time worker.
- Very little is known about the quality of child care. Most parents prefer care in their own homes, but often find this is difficult to arrange. Resolution of the ideological debate about quality and adequacy of care seems unlikely in the absence of consensus concerning the proper goals of child care.
- Almost all parents who use child care services report that they are satisfied with the quality of the arrangements. However, 21 percent of households using child care reported problems

severe enough to change arrangements. About 48 percent of those who changed used family day care.

- In 1986 the average cost of full-time child care for pre-school children was $3,023 a year. For a family of four at the federal poverty level, 50 weeks of care for one child consumed 27 percent of income, while two children in care pushed the family's child care bill above half of income. Even moderate-income families are hard-pressed by child care costs.
- The increase in California's children (ages 6-14), and the entrance of more women into the work force, makes it likely that demand for child care will increase.
- California's child care system and early childhood programs are likely to grow increasingly inadequate both in scope and quality, despite this state's leading role in the development of policy in this area. In the view of most observers and advocates, the current system is plagued by disarray and deficiencies.
- Lack of information or availability appears to prevent a significant number of parents from using centers or family day care. Other families encounter insurmountable problems with cost, scheduling and location. Public programs serve less than 9 percent of eligible poor children.
- California now faces a clash between increasing demand and inadequate funding for child care. The discovery of new child care needs—after school care, infant care, and care for handicapped children—exacerbates the feeling that public subsidies are inadequate. Moreover, real resources committed to publicly-subsidized programs have fallen 20 percent in the past ten years. These declining expenditures appear to have resulted in fewer children being served, as well as in the deterioration of the quality and evaluation of services.
- Limits on local property taxes have increased the state funding burden. California has had a system of centralized funding and diversified programs. It now seems appropriate, however, for the state to adopt the reverse: diversified funding and consolidated programs.
- Every report on children has called for an integrated program of children's services and a coherent state policy. But administrative divisions and the "California model" of highly targeted child care programs make such an approach difficult.
- The search for alternative revenue sources has generated many creative efforts to increase support among local governments and corporations. Valuable as such efforts are, they cannot now generate substantial revenues for child care. Effective revenue diversification would require changes in federal policy and in state law, and a new consciousness on the part of corporations and other private donors.

Chapter 6

Education

James W. Guthrie

- On average, California students daily spend more waking hours in school (approximately 15,000 before graduating) than in any other single endeavor. Even so, this is about one third less time in school than children in many foreign nations spend.
- Children find their schools and classrooms crowded, and the education system as a whole wobbles under the weight of trying to raise revenues, construct classrooms, and train teachers for the state's large (5 million) and growing number of students.
- The racial and ethnic diversity of children in California schools is unprecedented. Certainly no other state, and probably no other nation, has students from as wide an immigrant spectrum as does California. Approximately 16 percent of public school students were born in another nation.
- Despite the breadth statewide of cultures and races, many children, and most white children, attend local elementary schools and classrooms with students like themselves. This racial isolation occurs primarily because of income disparities

and residential housing patterns, not because of a deliberate state policy.

- Large and growing proportions of California's school children are from social backgrounds frequently linked with low academic achievement. Almost one quarter of them are from poor households and one seventh are not proficient in English.
- California's children attend classes with many more classmates than do other American children. These large classes reduce the time for individualized instruction.
- California invests only minimally in children's schooling. The state spends less per pupil than the national average, less than other major industrialized states, and a stunning $2,500 (almost $75,000 per classroom) less than New York state. However, the huge numbers of children involved statewide, plus constitutional impediments to added spending, render it unlikely that public investment will be increased in the short run.
- Academic achievement of California's top-performing students compares favorably with that of their counterparts throughout the nation. Black and Hispanic school achievement, while still below average, has been increasing. Elementary students study and perform well in standard academic subjects, e.g., reading, mathematics, and written language. Secondary students increasingly enroll in rigorous academic courses.
- These favorable facts mask unsettling conditions. Only slightly more than a quarter of high school graduates have taken courses permitting them to attend state universities. California students have great difficulty with problem solving and the more complex higher order skills.
- High secondary school dropout rates doggedly persist, and the academic performance of large numbers of secondary school children is so poor that they are unlikely to participate effectively, either as workers or as citizens. Despite these conditions, students, when surveyed, express substantial satisfaction with their schools.

Chapter 7
How Children Spend Their Time and How Community Factors Affect Their Well-Being
Donald E. Miller and John B. Orr,
with Marc J. Ventresca and Claire Smrekar

- Neighborhoods shape the life of the child. They are the child's universe. And the nature of that universe—rural or urban, homogeneous or cosmopolitan, nurturing or forbidding—in large measure determines the character of that child's social life and access to recreational and educational resources.
- Children's leisure activities are also affected by social and economic factors such as social class, family status, parental values, ethnicity, physical health, and personal values.
- Between one-fifth and one-third of school-age youth belong to voluntary youth organizations. Many of the functions previously performed by the family are now assumed by formal youth organizations.
- The constituency of youth organizations is changing. Children from low-income and working families are increasingly targeted, and many single-sex organizations have gone coed.
- Many children spend significant amounts of time participating in organized sports programs. Among Oakland sixth-graders, for example, half of the girls and almost three-fourths of the boys are active in at least one sports program. Teenage boys spend about an hour a day in these activities, girls about half an hour.
- Girls today find greater opportunities for participation in organized sports. As one measure of this trend, two girls for every three boys now earn a varsity letter, as compared with the one for every three who earned letters twenty years ago.
- Recreational participation suffers from limited availability of facilities in some parts of the state, and from limited accessibility in other places. In Los Angeles, Hispanic children find

themselves with a surplus of baseball diamonds and a drastic undersupply of soccer fields. Elsewhere in the state, parents worry about the safety of recreation facilities and of the neighborhoods in which the facilities are located.

- California libraries are struggling to adapt to demographic and social trends affecting children. Though many immigrant children remain unfamiliar with the local library, their sheer diversity requires that in San Francisco, for example, children's materials be collected in 37 languages. Throughout the state, children of some working parents are using libraries as de facto after-school day care centers.
- Religion plays an important role in the lives of half of America's teenagers. In the western U.S., one third of high school seniors attend services once a week or more, while an additional sixth go once or twice a month. Black teenagers are more active in religion than are white teenagers.
- Children spend more waking hours watching television than they spend in any other single activity over the course of childhood. Black children watch considerably more television than do white children.
- Youth devote about one-fifth as much time to music listening as they do to TV watching.
- A greater proportion of youth works today than ever before. Two out of three high school students do part-time work, the major out-of-school activity of older teens. A fourth of all seniors work at least 26 hours per week, with possible detriment to their studies. Girls and boys work about the same number of hours, but their jobs remain sex-stereotyped.
- Youth work mainly at minimum wage jobs and do so to have spending money. The disposability of teenage income reflects an intensification of teen consumerism.
- Many of the activities in which children spend their time are made possible by local governments and by the voluntary sector. If opportunity is not equitably available, this reliance on localities and voluntarism may increase the disparity of resources across neighborhoods, cities, and counties. Children from low-income areas are thus more likely to lack the variety and quality of programs and facilities publicly available to children in more affluent areas.
- The well-being and enrichment of children is best assured by the availability of a wide diversity of recreational and educational facilities and programs.

Chapter 8
Health

Neal Halfon, Wendy Jameson, Claire Brindis,
Philip R. Lee, Paul W. Newacheck,
Carol Korenbrot, Jacquelyn McCroskey, and
Robert Isman

- Medical and public health developments in this century have substantially improved children's health. Infant mortality has declined dramatically; treatment of childhood diseases has improved and immunization has virtually eliminated several previously common childhood diseases.
- The vast majority of children in California are considered to be in excellent or good health by their parents. Fewer than 10 percent of California children are considered to have severe health problems and/or chronic disabilities that limit their activities. But parents of poor children are two or three times more likely to report their children are in poor or fair health.
- The conditions of children's health requires more than an examination of diseases and impaired functioning. The effects of poverty, poor nutrition, parental neglect, adult drug and alcohol abuse, child abuse, and risk-taking behavior are currently endangering children.

- Accidents, suicide, drugs, and violence have increased in importance relative to infectious diseases as problem areas. In the 5-14 age group, intentional and unintentional injuries rank as the leading cause of death. Adolescents are the one group in society with an *increasing* mortality rate. But, interventions are difficult to identify, target, and sustain with sufficient intensity to make a difference.
- Existing categorical programs do not adequately address the health needs of growing numbers of very high risk children (children in foster homes, teenage mothers and their babies, drug exposed children, and homeless children). Moreover, the fragmented delivery of many health and related social services makes multiagency integrated services exceedingly difficult.
- There are no clearly defined or agreed upon health goals. A revised policy would define good health, gather data related to children and family health, conduct a needs assessment, and propose programs for addressing such needs.
- White children, on the average, visit a doctor more than one-and-a-half times more often than do minority children. This lack of preventive care may lead to more serious ailments that must be treated in hospitals or by other expensive interventions.
- California has traditionally had a low rate of infant mortality compared to other states, but has fallen in rank recently (7th in 1970 to 14th in 1985). In 1985, the infant mortality rate in California actually rose. This increase may be related to health care gaps or changes in adult behavior such as drug abuse.
- Infant deaths due to prematurity and birth defects have three clear "risk factors"– race, low socioeconomic status, and low level of education. Black infant mortality rates are nearly twice that of whites.
- A substantial proportion of infant mortality is preventable, particularly through the prevention of low weight births by improving the content, access and utilization of prenatal services to low-income women who are at high risk of having low birth weight babies.
- Unemployment and changes in employment patterns (for example, small, service-oriented businesses) have left many women uninsured. Women in families with incomes below the poverty level, while constituting only 17 percent of reproductive age, constitute 37 percent of the uninsured, even when those with Medicaid are included among the insured. Black women are 1.5 times as likely as non-Hispanic whites to be uninsured. To the extent that low-income births will rise, birth outcomes can be expected to worsen until women have access to effective prenatal care.
- Although a 1987-88 survey of drug and alcohol use among California students found the percentage of seventh- , ninth- , and eleventh-grade students who have used these substances has declined, the numbers still remain high. More than forty percent (42.4%) of eleventh graders reported that they had tried illegal drugs and 61.5% said they had been drunk at least once by the time they were age 16. Nearly half (45.8%) of all eleven year olds said they had tried alcohol; 10% said they had gotten drunk.
- The numbers about cigarette smoking are more encouraging. Nearly three-quarters of eleventh graders (73.3%) reported in 1987-88 that they had never smoked a cigarette.
- There is some evidence education programs may be having an effect. On the 1988 survey of students, 63.1% of eleventh graders said they had learned in school that drugs and alcohol are harmful.
- Drugs and alcohol continue to be serious problems, especially in poor and minority communities. For adolescents confronted with school failure, an unsupportive home environment, and perceptions of few life options, use of drugs and alcohol often present a too-attractive alternative.
- Sexual activity has increased among American adolescents since the early 1970s. National statistics show the average age at first sexual intercourse is 17.1 for females and 16.5 for

males. By age 20, three out of four females and five out of six males will have had sexual intercourse at least once.

- California has the second highest teenage pregnancy rate in the country: for 15-19 year olds, it is 143 per 1,000. One in ten of California's pregnant teenagers did not receive any prenatal medical care or did not begin care until the third trimester.
- In 1985, California's public costs for families begun by the first births occurring while the woman was a teenager were $3.08 billion dollars. Had these births been delayed until the mother was 20 years old, 40 percent—$1.23 billion dollars—would have been saved in 1985.
- The California Immunization Program combines the efforts of the California Department of Health, local health departments, and the private sector to prevent, control, and eliminate vaccine-preventable diseases.
- Currently, over 96 percent of California's kindergartners have received adequate immunizations for measles, rubella, and mumps. DPT and polio vaccination rates are slightly lower because of difficulties in making sure the child received the whole series.
- Stronger laws more strictly enforced, such as those requiring students in grades K-12 to show adequate immunization, have been a major cause of higher immunization levels, although poorer children and minorities are still at greater risk of not being immunized.
- In the last decade the cost of completely immunizing a single child through public vaccination programs has risen an astonishing 700 percent from $5.00 to $32.00, largely as a result of manufacturers responding to skyrocketing liability insurance costs.
- Added immunization programs should be targeted to high-risk groups—toddlers, teens, and families in poverty. New immigrants continue to suffer linguistic and cultural barriers that inhibit their access to immunization.
- Although the vast majority of children have access to adequate quantities of nutritious food and do not go to bed hungry, there are indicators of a growing problem of malnutrition and hunger.
- California supplements federal food programs with state funds and serves children through programs like Food Stamps and School Lunch. In 1985, 60 percent of the members of households participating in the Food Stamp Program were children. Food stamp benefit levels, however, have not kept pace with the inflationary increases in food costs.
- Dental caries and periodontal diseases are the most prevalent diseases affecting California children. Poor and minority groups have much greater prevalence of dental decay than their wealthier, non-minority peers. Data from the 1983 National Health Interview Survey indicate that poor and minority children were significantly less likely to have made a dental visit in the past year, and were far more likely to have never seen a dentist, than higher income and white children.
- Community water fluoridation remains the most cost effective method available for caries prevention. While nationally 67 percent of community water supplies are fluoridated, only 17 percent of those in California are. Almost all major U.S. cities have fluoridated water; however, Los Angeles, San Diego, San Jose, and Sacramento remain unfluoridated.
- Half of dental decay can be expected to occur by kindergarten, yet only 10,000 preschool age children are currently enrolled in a state program to prevent tooth decay.
- Although the proportion of the population with dental insurance has increased substantially over the last 20 years, poor and minority group children still rank low. Medicaid has been ineffective in alleviating this problem. Medicaid children were only two-thirds as likely to receive a dental examination as children in general and only slightly more than half as likely as the average privately insured child.

- The lack of availability and accessibility of dental services in California is worsening. MediCal needs to be restructured to include more dentist participation, alternative funding mechanisms, and publicly-funded dental care programs where no providers exist to serve children who need care.
- The Child Health Disabilities Program (CHDP), which offers health assessment screening services, including a health history, physical examination, immunizations, vision and hearing test, nutritional assessment, and a variety of screening and lab tests, serves only 22 percent of the eligible children.
- Development disturbances can be physical, mental, emotional, or a combination of these. California has two main systems for delivering developmental services: special education in the schools and assistance provided by the California Department of Developmental Services (DDS).
- California's schools provide special education for 400,000 mildly to severely handicapped students.
- DDS clients have specific limiting conditions that are not primarily physical in nature but stem from problems in the central nervous system; for example, cerebral palsy, epilepsy, and autism. Children with severe physical disabilities are generally served by California Children's Services (CCS).
- CCS considers almost all catastrophic physical conditions eligible. Financial eligibility is more liberal in California than in many other states. Currently, children are eligible for CCS services if family income is below $40,000 a year or if medical care expenses exceed 20 percent of family income.
- In the last two years, CCS caseloads have increased substantially, from an annualized rate of 74,000 during the first part of 1984 to one of 87,000 during the first part of 1986. However, expenditures for CCS have not kept pace with increased caseloads.
- The United States has not developed a health care system that can guarantee health care to all citizens. The coupling of health insurance with employment means that economic trends, such as rising unemployment, will increase the number of uninsured children.
- MediCal is the primary insurer for children in poverty. MediCal currently serves 1.5 million children and has standards of eligibility and benefits that are generous in comparison to other states—California provides 32 of the 33 optional services that states can elect to provide under federal regulations. However, MediCal children often do not receive quality care in comparison to those with private sector insurance.

Chapter 9

Mental Health

Donna Weston, Linnea Klee, and Neal Halfon

- Rapidly changing social conditions have dramatically affected the range of cultural and family situations that may be associated with mental health problems. Although these risk factors are still not adequately understood, changing family structures, economic hardship, genetic and biological factors, and the dynamics of "dysfunctional" families are important factors.
- Identification, diagnosis, and treatment efficacy for psychological and emotional problems remain highly uncertain, with effectiveness data scarce and difficult to interpret. Data on frequency of different types of problems and disorders, age of onset, severity, and other prevalence data are largely unavailable.
- Estimates of severe emotional disturbance range from about 2 percent, or 142,000 children, to 8 percent, or 568,000 children. Nonetheless, *fewer than 10,000* children and adolescents in California's public schools have been identified as severely emotionally disturbed.

- More than 50,000 California children and adolescents are in foster care. The prevalence of emotional, behavioral, and developmental problems among these children is common. Studies report between 30 and 80 percent of foster children examined for psychological problems to be moderately to severely impaired.
- Abused children often come from highly stressed, multiproblem families, warranting a family and child treatment focus.
- Alcohol use in pregnancy can lead to mental retardation and fetal alcohol syndrome in offspring. An increasing number of babies are being born to women using drugs, particularly crack/cocaine, resulting in a broad range of developmental problems for newborns.
- Public policy has not been targeted to the establishment of a continuum of mental health services to meet the continuum of need. Services are heavily weighted toward expensive inpatient hospitalization and are not balanced with improved residential, outpatient, and preventive services.
- Determining the expenditures for children's mental health services is difficult because funds for children are intermingled with resources for adults. Despite the broad array of government and private funding, gaps in resources and services remain.

Chapter 10

Child Abuse and Child Welfare Services

Richard P. Barth and Marianne Berry

- Increases in reports of child abuse have strained the welfare system. In 1987, California investigated 61,090 reports of child abuse. Between 1981 and 1988, reports of physical, sexual, and emotional child abuse rose 212% in California.
- Two out of three families reported for child abuse receive no preventive, interventive, or follow-up services. (The state currently has no common definition of "substantiated child abuse.")
- Recipients of child welfare services in California are disproportionately members of minority groups. More than half the families whose children are under court-ordered protection at home are minorities. Black children are reported for abuse and receive formal services at twice the rate expected by their proportion in the population.
- Homeless children have no predictable place in the child welfare system. Since the mid-1980s, the focus on children at risk of physical and sexual abuse has left the increasing numbers of homeless and neglected children virtually without child welfare services.
- California's policy of family reunification, coupled as it is with inadequate support and insufficient follow-up services, fails adequately to protect children from subsequent abuse.
- Each year, one out of every one hundred California children spends time in foster care. In 1988, the number of California children in foster or residential care reached 44,337.
- Despite the large number of children in foster care, California still has an inadequate number of foster care families. Without increased funding for foster care, the quantity and quality of foster parents will continue to decline as the numbers and needs of children increase.
- Studies show that adopted children fare better in the long run than do children placed in foster care. Nevertheless, compared to other states, California has a smaller proportion of adoptions and a larger proportion of foster care placements. Only 30% of children in foster care in 1985-86 were recommended for adoption.
- Assuming no changes in the existing level of services, and assuming that homelessness, substance abuse, and child abuse and neglect remain at their current level of severity, the quality of children's lives will diminish.
- In order to make informed policy and practice decisions, California needs a statewide data management system that

tracks individual children across time and services plus a system of key indicators of specific harms suffered by children and critical conditions of family life.

Chapter 11

Children, Delinquency, and the Law

Thomas David and Marc J. Ventresca

- Many indicators and measures of criminal activity among youths have posted steady declines since the early 1970s. Yet the youth population incarcerated in state and county facilities shows substantial and continuing increases, as do other system indicators as the average period of incarceration, length of probation, and average probation load.
- From 1980 to 1985, the statistics on correctional populations show significant increases. The number of juveniles on probation rose by 66 percent; juveniles in county detention centers, camps, and ranches grew by 24 percent, and the juvenile population of the Youth Authority grew by 66 percent. In all, there were 85,941 Californians under age 18 who were being controlled by various state and local correctional agencies. The proportion of California youth under correctional supervision increased by 50 percent between 1980 and 1985.
- These data portray a system that is becoming more formal, more restrictive and more oriented towards punishment. In addition, probation caseloads have increased to levels that make adequate supervision unrealistic and county and state facilities face chronic and severe overcrowding.
- Juvenile justice in California is not an integrated or coordinated system, but rather a collection of agencies tied together for the processing of juvenile offenders. There is often a lack of linkage between prevention programs, corrections, probation, and social support services.
- Policies vary greatly among counties. Some counties have no local facilities and commit juveniles with low-level offenses to state facilities with hardened criminals.
- California incarcerates a higher proportion of its juvenile offenders than do other states with comparable large and heterogeneous youth populations.
- Data on the characteristics and conditions of youths in the juvenile justice system are rudimentary and largely administratively driven. There is a paucity of information about access to educational opportunities, training and rehabilitative programs, and about the quality of life of incarcerated youths. The diversity in legal definitions of delinquency, inaccuracies in counting, and inconsistency in enforcement make it difficult to fix a "true" incidence of delinquency itself.
- Contrary to popular belief, fewer California youths had contact with the legal system and juvenile arrests actually declined through much of the 1980s. Arrests have increased slightly in recent years, paced by increased drug arrest rates (22 percent), especially for narcotics (70 percent). Nevertheless, rates remain at levels well below those of the 1970s.
- As a group, juveniles in California are 45 percent more likely to be arrested than are adults. Variations occur, however, among specific crime categories. Property crimes account for the majority (62 percent) of juvenile felony arrests. Juveniles account for 26 percent of all property-related felony arrests.
- Boys accounted for 77 percent of all juvenile arrests. Most juvenile arrests are white (53 percent), with Hispanics 28 percent and blacks 25 percent.
- Older youth, boys, certain racial and ethnic minorities, poor and urban youth are all more likely to be arrested. But substantial variations exist by county, reflecting variations in the structure and practice of juvenile justice, as well as differences in county youth populations.

- The discretion exercised by law enforcement agencies and individuals (police officers, etc.) in deciding which individuals should be entered into the system and for what behaviors further contribute to variation in practice.
- The average length of stay in the California Youth Authority has increased from 12.7 months in 1975 to 17.4 months in 1988.
- Policy makers and the public at large have not reached a consensus on how to improve juvenile justice. Opinion polls show that although the general public wants less leniency in the courts, there is also continued endorsement for treatment and rehabilitation as the primary purposes of juvenile corrections.
- Worthy treatment and rehabilitation objectives must be balanced against the need to protect the public, to communicate an appropriate social sanction for wrongdoing, and to effect restitution both to victims and to society at large.
- The burgeoning population of incarcerated juvenile offenders will require substantial increased operational and capital funding from the state. As California reaches legislated spending limits, increasing juvenile justice costs may mean reducing state and local ability to pay for other social services.

Chapter 12
Income Support Programs
Jacquelyn McCroskey

- About two thirds of AFDC recipients are children; in 1986, an average of 1,098,000 California children per month relied on AFDC for the basics of life.
- Overall, AFDC recipients are younger, have less education and higher levels of poverty, are more likely to be nonwhite, and have younger children than do child support recipients.
- California's need standard for AFDC was more generous than that of any other state in 1970, but by 1987, 13 states had more generous need standards, thus providing access to a broader range of families.
- Though locally administered, income programs are authorized and primarily financed by the federal government. In large measure, federal decisions drive the programs and shape the context in which California's state and county governments can operate. California must continue to assure that counties have the flexibility to effectively meet widely ranging local needs.
- California's welfare reform program—Greater Avenues to Independence (GAIN)—was designed to offer a comprehensive range of services, including job search, basic adult education, English as a second language, career assessment, vocational education, on-the-job training, transitional employment, pre-employment preparation, child care, transportation, and other support services. However, the program is not yet fully implemented and budget restrictions may significantly limit the scope and effectiveness of the intended reform.
- GAIN provides a timely opportunity to rethink income support policies and to improve the conditions of families living in poverty. Establishing formal relations between county welfare departments and economic development agencies, colleges, occupational centers, child care providers, and other major service providers will be challenging, but may bring a fragmented system into closer alignment, an outcome with potential long-term benefits for California's families.
- Almost one million (942,248) California households received child support in 1984-85, and approximately half were also AFDC recipients. The average monthly child support payment per household in California for the first quarter of 1986 was $159.74, while the U.S. poverty guideline was $150 per month per child.
- State and national studies suggest the need for systemic changes in California's child support program, including

mechanisms for determining paternity, standard of need, and training of enforcement personnel. The child support program has not been conceptualized as a complement to the welfare program or adequately integrated into its administration.

- Although data collection systems are not yet at the point where individuals can be tracked across programs, it should be possible to develop better methods of aggregating data across programs serving children. In order to do so, policymakers must redefine the optimal administrative and conceptual relationships between systems to reflect the multiple needs of families and children rather than the convenience of departmental categories (for example, relationships between income support and the need for child abuse or juvenile justice services).
- Programs which provide basic food and shelter for children are manifestly beneficial both for children and for society, but there is too little research which examines how California's children are affected by its income support policies. The available data focus on systems and fiscal accountability issues rather than on the beneficial or deleterious child outcomes of current or potential income support strategies.
- A changing economy, along with recognition of the current welfare system's inadequacies, is rekindling debate on income support policies for children in California. Is it the purpose of income support programs to provide a minimum acceptable level below which no child shall be allowed to fall, or is it their purpose to ensure that parents achieve economic independence? Should parents retain the economic responsibilities of providing for their children regardless of ability to fulfil those responsibilities? What kinds of strings (for example, parental work obligations) should income support benefits carry?

Chapter 13

Policies for Children with Multiple Needs

Shirley Brice Heath and Milbrey Wallin McLaughlin

- This analysis is derived largely from the preceding chapters that demonstrate problems in service provision, conceptualization of needs, availability of data, and implementation of youth policies. The earlier chapters stress that such areas as poverty, juvenile incarceration, and child care are increasing, while children's services are overloaded, underfunded, static, and out-of-sync with dynamic societal changes.
- Children with multiple needs are underserved because of a lack of preventative services, failure to help children over time, failure to meet enough of a child's needs to assure a satisfactory outcome, and lack of coordination across service areas.
- The policy structure itself is beset by problems resulting from separate funding streams, inconsistent eligibility criteria, splintered organization of interest groups, and legislative jurisdictions that preserve service fragmentation.
- More money for the existing melange of programs will not provide the crucial improvement for children with multiple needs. Nor can any single entity, such as the school or family, deal effectively with interrelated youth problems.
- California's policies have not kept pace with the state's current and projected demographic picture of altered family life. Changing demographic characteristics have driven policymakers to respond to the needs of separate institutions that plead for segmented state action and funding.
- Few county departments have developed mission statements or department-wide master plans for children that identify the department's goals and objectives, integrate resource allocation and service delivery systems, assess the effectiveness of their efforts, or coordinate activities of divisions within departments.

- Few schools or services assist youths to deal with either the work world or the bureaucratic maze of public services. Adults in both schools and service agencies talk *at* youths, labelling their problems and fixing solutions dictated by administrative fiat or "that's just how it's done" procedures.
- In the short range, policy should focus on underservice and underfunding in such areas as child abuse, education, and health. In the long run, the goal should be to overhaul our current policy approach.
- Institutions tend to treat problems as acute rather than chronic, as episodic rather than continuing, and do not regard themselves as learning environments that help children help themselves.
- The data collected rarely inform reflective or dynamic responses by those within the agencies. Data focuses on financial "inputs" into programs, rather than outcomes. Information is administratively driven in the interest of service stabilization, and promotes reactive and prescriptive, rather than proactive and preventive, reforms.
- Service professionals within agencies seldom view their work as interactive and interdependent with the work of those in other agencies. Inadequate interprofessional preparation often begins at the university. Professionals such as teachers, nurses, and probation officers are prepared in segmented schools and programs that rarely stress the interrelatedness of children's problems.
- Promising local efforts to restructure and reconceptualize youth services have a number of common features. These features include outside flexible funding, top level commitment, implementation tailored to local contexts, middle-level administrative cooperation, and prior experience in trying to integrate services.
- Much of the duplication and confusion of fragmented children's service delivery can be prevented by providing related services at the same site such as schools. Where possible, services targeting a shared clientele should be located under one roof.

Chapter 14
State Policymaking for Children
Claire Smrekar

- A set of historical, political, organizational, and ideological forces has combined to shape a children's service delivery system in California described as fragmented, inefficient, and ill-conceived.
- Children's policy has evolved in response to a series of incremental and explosive periods in social welfare policy over the past several decades. In the 1960s, the Great Society gave birth to large categorical programs developed to target services for vulnerable children and their families. The Reagan Administration's New Federalism ushered in a period of consolidation and realignment as major categorical programs serving children were collapsed into block grants. Fundamental shifts in decision making, governance, and accountability accompanied these sweeping programmatic changes.
- A series of reports, hearings, and commissions has examined the condition of children's policy in California and recommended an array of organizational and regulatory remedies. Most recommendations involve relatively modest efforts to construct organizationally greater control, coordination, and efficiency in the delivery of children's services. Few of the recommendations involve a more sweeping, substantive exploration of the ways in which children's needs are perceived and defined.
- Despite the flurry of programmatic initiatives— including state legislative committees on children, children's budgets, children's codes, and commissions on children— most states continue to organize and deliver children's services through the traditional executive agency arrangement. At both state and local levels

of government, the bureaucratic structure persists in an array of eligibility requirements, procedures, standards, categories, assessment tools, and treatment protocols. In response, states (including California) and localities have adopted various approaches aimed at improving communication processes, coordination, and integration of services within these existing bureaucratic arrangements.

- A supportive and responsive children's policy must ultimately evolve out of a process which takes account of the complexities of childhood and the ambiguous relationship between family and state. By fostering the cooperation of the childserving professions across such fields as education, health, and social work, the process of crafting a children's policy for California can move toward this goal.

Working Paper

An Exploration of County Expenditures and Revenues for Children's Services

Paul Goren and Michael W. Kirst

Editor's Note: This working paper is not included in the PACE Report but is available through the Berkeley PACE office.

- State and federal lawmakers increasingly look to county governments to provide a growing array of mandated programs for children, and often require counties to share the cost of these services. As a result, counties are now the major governmental providers of an ever-expanding list of children's services, other than education.
- Though expected to bear a larger share of the burden, county governments are facing local and state constitutional revenue constraints that ill-equip them to respond to the growing need for children's services.
- At the county level, funding for children's services is composed of a volatile mix of revenues, with an overwhelming and precarious dependence on federal and state monies. Reduced federal support for social services, together with the dual mechanisms of Proposition 13 and the Gann limits on state spending, have required counties to do more for children with less resources.
- Counties are left unable to raise local revenue necessary to support non-mandated, discretionary programs such as children's protective services and child abuse prevention. Some localities are unable even to participate in federal or state matching programs for children, simply for the lack of local matching funds.
- The intensifying competition for scarce resources exerts a fiscal "squeeze" on children, as counties ration their children's services to stay within budget limits. County officials report cutting children's services in order to fund adult correction and other state- and federally mandated services for adults.
- By forcing children's programs to focus on acute care rather than on prevention, present policies create a potentially negative cycle of long-range implications for the condition of children.
- Few California counties collect data on their total expenditures on children. More coherent children's policy requires better data systems and analysis at the county level.

Working Paper

Child Care Quality from the Child's Perspective: A Hypothetical Account and Research Review

Lyda Beardsley

Editor's Note: This working paper is not included in the PACE Report but is available through the Berkeley PACE office.

- This monograph, written as a narrative, considers the growing body of research on child care quality from the *child's* perspective.

- Over the past decade, early childhood educators and researchers have begun to identify a number of characteristics they believe are essential to the provision of quality out-of-home care for young children.
- Indicators of quality of care cited include adult/child ratio, group size, caregiver training, quality of adult-child social or verbal behavior, and effects on specific outcomes (i.e., on language or social development) for children in care.
- Yet no previous study has described the *cumulative* effects of specific quality indicators on the overall character of a child's experiences in child care.
- This report takes a fresh look at current quality issues in child care from the perspective of the child by introducing a group of fictional preschool age children and following them through a hypothetical day in each of two quite different child care settings. Though fictional, these accounts are based on a sampling of real events in both good and poor quality child care facilities.

Chapter 1

Introduction

By Michael S. Wald

During the 1980s Americans have expressed considerable alarm regarding the well-being of our children and youth. A recent Harris Poll[1] found that:

- Nearly three out of four Americans (74 percent) believe that problems affecting children have become worse since they themselves were growing up
- Only a minority of the public (43 percent) thinks that parents are doing a good job of meeting their responsibilities to children
- Less than half of the public (43 percent) thinks that schools are doing a good job.

Echoing the general public's pessimism concerning the welfare of children, the business community has also been expressing fear about the educational performance of U.S. children. Recently, the Committee for Economic Development, made up of 225 heads of U.S. corporations, stated that "our industries will be unable to grow and compete because an expanding educational underclass will be unable to meet the demands of such jobs."[2]

Societal concern over the condition of children is not new. Throughout our nation's history, politicians, community and religious leaders, academics, and the general public have all expressed concern over the decline of the family and the state of the child. Yet, viewed historically, the condition of most of California's children has improved in many ways. Although, as we shall show, there are some disturbing trends in children's well-being, the *majority* of California's children are healthier, wealthier, and have completed more schooling than at virtually any time in our history. In addition, over the past thirty years government and private agencies have invested substantial sums of money in an effort to meet the needs of children with special problems such as learning disabilities, chronic illness, physical disabilities, families that do not speak English, and abuse and neglect.

Is the condition of children in California getting better or worse? Or both? Are children doing poorly in particular areas of development? Which children? What measures are available, and appropriate, for judging the well-being of children?

To answer these questions, we need a set of "social indicators" that can be used to describe the conditions of children. This report is a first attempt to put together a comprehensive set of such indicators for children in California. It is designed to provide information needed by state and local government officials, program planners, providers, advocates, and researchers who are working to meet the needs of children. It pulls together information not otherwise readily available to policymakers and identifies gaps in available data. Although our primary purpose is to provide information, many chapters also contain some policy recommendations.

Our ultimate goal is to describe the quality of life of California's children. However, no simple measures capture the quality of life for children. Therefore we look at many areas of development that contribute to children's well-being; these areas include physical and mental health, physical safety, academic achievement, and behavioral problems (such as drug and alcohol abuse).

We also look beyond data that describe children directly. We have tried to provide a picture of the environments in which children grow and the institutions that serve children—families, day care settings, schools, and the health care, child welfare, and juvenile justice systems. We look also at the settings in which children are found—their neighborhoods and the public and private organizations (such as libraries, 4-H Clubs, and Scouts) in which they play and learn.

We examine these settings because, in general, children cannot provide for their own well-being. Their condition is only as good, or as bad, as the condition of those people and organizations charged with protecting and promoting their well-being. Moreover, in the absence of data that provide a direct picture of children, information about these institutions provide our only evidence of some aspects of children's well-being. A significant body of research has demonstrated a relationship between the quality of caretaking and the well-being of children. Although such research is complex, and must be used cautiously, it directs us to some important indicators of the likely condition of children.

Information about the condition of children could be organized in many ways. We have chosen to begin with a demographic perspective, examining long-term trends related to children in California and the United States. Although the well-being of each child ultimately rests on a set of conditions particular to that child, the general well-being of children is greatly affected by the number and proportion of children in the general population and by the composition of the general population.

We next look at the condition of the major settings in which children are found—families, child care facilities, schools, and neighborhoods. Resources for children must be filtered through the adults, parents, foster parents, teachers, day care providers, social workers, and others who provide the love, care, teaching, and protection that children need. To the extent that these people lack commitment, skills, or resources, the condition of children will suffer. Likewise, if these adults are not empowered to do their jobs well—supported by adequate resources and facilities—children suffer.

We then examine specific aspects of children's well-being. These aspects include children's health and mental health, the condition and treatment of abused and neglected children, and the needs and treatment of delinquent youth.

In the final part of this book, we sketch the current way in which government agencies develop policy toward children, describe several major programs designed to support children, and outline the way in which various systems are funded.

Although the report is organized into chapters that describe discrete aspects of children's development or particular service systems, we have attempted to do more than simply compile data pertaining to these topic areas. As did the authors of a similar report from New York, we present and discuss trends so that "emerging issues can be identified and children's progress on long-standing issues can be assessed."[3] In some instances, the trends identified reveal crucial interrelationships among the various topics presented in individual chapters. For example, although the high and rising level of poverty affecting California's children is a significant problem in and of itself, the poverty level also is related to changes in children's health care, the need for child care, and placement into out-of-home care. Similarly, changing family composition and demographic changes have far-reaching implications for other aspects of children's lives. Therefore, although each chapter is written to capture a single and important aspect of a child's life, a more thorough understanding of the problems faced by children can be obtained from reading the entire book.

Read as a whole, the report captures many aspects of the quality of life of California's children. We were not able, however, to capture a crucial component of a child's world—the psychological environment in which he or she grows up. How valued and wanted do children *feel*—at home, in school, in child care, in their neighborhood, in the society at large? We would have liked to capture these aspects of children's well-being—they may be the most important—but there are no reliable data on these issues. We also have only very limited data reflecting children's views of their world. Thus, the information in this volume should be viewed as a useful, but incomplete, picture of the quality of life of California children.

Some Major Themes

Although we were largely unable to capture the complexity of the lives of individual children or to determine the number of children who, in some overall sense, are doing "well," "poorly," or "in between," several major themes do emerge. They provide a start for

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thinking about those aspects of children's lives and well-being that should concern policymakers.

The first theme relates to the changing nature of California's population and the composition of its families. More than 7 million children now live in California. That number will increase substantially in the next ten years: by the year 2000, 1.3 million more children will live in California than do at present.

The family backgrounds of these children will be increasingly diverse. Much of the increase will result from immigration into California. Children from ethnic or racial "minority" groups now constitute half of all children in California; they will constitute a substantial majority of the children within ten years.

Second, if the recent trends with regard to fertility, births to unmarried mothers, divorce, and parental employment remain basically stable, an increasing portion of children will be born to poorer families, a substantial number of children will spend at least part of their childhood living in a single-parent family, and most children will spend a substantial time each day in the care of adults other than their parents.

The impacts of these changes are complex, not easy to measure, and vary child by child. However, it appears that the increase in divorce and births to unmarried mothers, especially young unmarried mothers, has increased the number of children who experience health, academic, and social problems.

A third major theme is that California, and the nation as a whole, have been developing two groups of children—one advantaged, one disadvantaged. In the past ten years, the gap between the most advantaged and most disadvantaged has grown. Although many children are much better off in terms of physical health and safety, family wealth, and educational opportunities, a substantial, and perhaps growing, number of children are being left behind. Although more children are completing high school and going on to college, others are dropping out of junior high school—at a time when even a high school diploma may not be sufficient preparation for earning a decent living.[4] And, most disturbingly, the division between "haves" and "have nots" lies, to a large degree, along racial and ethnic lines—on most measures, nonwhite children are in considerably worse condition than white children.

A central factor distinguishing the two groups is poverty. In every area of development, such as physical health, academic achievement, and emotional well-being (as reported by children themselves), the condition of poor children is, on average, worse than that of children who live in families with adequate incomes. Moreover, the problems seem to be cumulative—poor children who experience difficulty in one area of development tend to have problems in many areas.

It must be recognized that we do not know the extent to which poverty itself, or other characteristics of poor families, account for the problems poor children experience. Still, it is clear that poverty alone has a direct impact on access to goods and services and on the quality of the child's life. In many areas—health care, child care, social services—California already invests more heavily in children than does virtually any other state. Yet these investments reach only a small percentage of the children who currently need them. The changing demographics will certainly increase the need.

We want to emphasize that poverty is a very complex phenomenon. Contrary to public belief, most poor children in California live in two-parent families, not with single parents. Some children live in poverty for only a relatively short period of time, and others episodically, while some spend all or most of their childhood living in poverty. Some families are poor despite the fact that there are two working parents, because the parents earn low wages; others are poor because the only parent is young, a school dropout, and unemployed; still others are poor because divorced mothers, who generally have custody of children, often are left in poverty. Those concerned with the condition of children must be concerned not only with eliminating poverty; they also must try to understand what aspects of a poor child's life affect the child's well-being and future.

A fourth theme emerges from our examination of the institutions that serve children. For children, being in the care of publicly financed caretakers is no guarantee of being in good care. Children who come into state care, whether on a short-term basis (while in school or in publicly funded child care centers) or on a long-term basis (in foster homes, residential treatment facilities, or institutions for juvenile delinquents) often have many developmental problems. We cannot expect that all these problems will be rectified by state care. But we can certainly expect that these problems will not be made worse by care received at the hands of state agents.

Unfortunately, such expectations are not uniformly met; they may not even be met for the majority of children. Although there doubtless are extraordinarily good state-funded schools, day care centers, regional centers for disabled children, hospitals, foster homes, and residential institutions, many such settings are woefully deficient. Some do not meet children's basic educational or health needs, let alone promote emotional well-being. This failure is not (generally) due to an absence of good will or intent on the part of public employees, but rather to increasing problems in the structure and financing of children's services. Moreover, although information is sketchy, it appears that public systems that serve poor children are in worse condition than those that serve middle-class or wealthy children, and that in recent years the situation of the poor has become worse in California, both absolutely and in relation to other states.

The final theme that emerges is that, at present, California lacks any systematic means of gathering data about the condition of its children and any systematic process for establishing, coordinating, and evaluating programs designed to meet children's needs. California devotes a substantial amount of resources to children. However, there is no coherent state policy regarding where money should be spent, whether programs should be coordinated and, if so, how. Numerous agencies perform overlapping functions. Because services are delivered along categorical lines, children with multiple problems may go unrecognized or may receive services from a number of different agencies that do not coordinate their approaches. There is also an almost uncharted private sector, whose activities are generally not well coordinated with government programs.

Moreover, except for schooling, child care, and some preventive health programs, most state policy is directed at children with manifest and severe problems. The numbers of such children are growing. The numbers of abused and neglected children, of children in out-of-home care, of children born with AIDS or addicted to drugs, of children attempting and committing suicide, have increased dramatically in recent years. Although there are understandable reasons for the prevalence of categorical programs targeted at the worst-off groups, such programs often provide too little, too late to really improve the condition of children. Despite widespread recognition that a number of preventive programs are both cost effective and best for children, such programs remain scarce.

Some indications suggest that California is in a period of intellectual, as well as financial, retrenchment in its commitment to children. From the 1940s until the 1970s California led the nation in thinking about children's needs. Novel programs were developed in many areas—in health care (Child Health Disabilities Prevention Program/California Children's Services), in child care (campus child care), in the treatment of delinquency (California Youth Authority and county systems), and in responding to the needs of abused and neglected children (the 1977 California Family Protection Act). Although California retains leadership in some areas, over the past ten years (since the passage of Proposition 13) that leadership has faded. Despite the changing context in which children live, few new initiatives have been mounted on behalf of California's children.

It is clear from the data reported in this book that while some of the problems confronting children have been around for many years, others are new. They reflect the changing family structure, the impact of immigration, and the emergence of a small group of very disadvantaged parents, whose children are at great risk for poor physical, emotional, academic, and social development. These new problems require new policy initiatives and perhaps a new structure for developing public policy regarding the well-being of children. We hope that the data provided in this book will help guide policymakers who are looking for new directions.

Some Methodological Considerations

This is the first attempt to provide a comprehensive picture of the condition of children in California. In deciding how to organize our material, we benefited greatly from examining several comparable reports from other jurisdictions, especially those looking at the condition of children in New York City, in New York State, and in Illinois.[5] We also found that we faced many of the same obstacles as other researchers. Because we hope that this report will be updated and improved regularly, we here describe the process used to develop this report and the types of data that are needed in order for future reports to be more useful.

Selecting Indicators

Our goal was to select "statistical measures of clear normative significance believed to reflect meaningful aspects of the welfare of children or of the contexts in which children are reared."[6] Certain indicators seemed clearly relevant: infant mortality, physical health, mental health, cognitive development, and academic performance. In addition, indicators of significant problems—such as suicide rates, drug and alcohol abuse, and criminal behavior—are generally considered important measures of children's welfare.

As previously indicated, we believe that other aspects of development, a sense of self-worth, of being wanted, of security, also are critical to a child's well-being. Unfortunately, data are not uniformly available with regard to all aspects of children's development. "Data on the psychological well-being of children and on their social and emotional development are generally much less adequate than statistics on children's physical health and development, or on their intellectual development and educational achievements."[7] Because we believe that public policy should focus on children's emotional well-being, we report measures of these aspects of development, even if the measures are relatively inadequate.

In addition to deciding which aspects of well-being should be relevant, we needed to decide how the evidence should be interpreted. For some aspects of development, we have clear definitions and absolute standards against which we can assess children's conditions. For example, we can measure infant mortality rates, levels of immunization, and basic literacy. We know that we want literacy and immunization rates to rise—our goal is 100 percent coverage. Similarly, we would like to wipe out infant mortality.

With respect to other aspects of development, we have reasonably well-developed norms and measures, but not absolute standards. In many aspects of physical health (such as physical fitness) and academic achievement (such as ability to write well), our standards must be stated in relative terms. We measure each child's well-being in relationship to the general well-being or achievement of a group, not against an agreed-on absolute standard. Moreover, on some of these measures we cannot expect each child to meet or exceed the norm; genetic and biological differences set constraints for each individual.

The problem is much greater with concepts such as "self-esteem," "security," or "happiness." Child development specialists debate the definitions of these qualities, the methods by which they should be measured, and in some cases their relevance. Few, if any, measures exist that allow us to assess parental love or commitment.

Because few aspects of child development can be measured in absolute terms, we primarily describe the condition of children in relative terms; for example, on any given measure, how does the condition of today's California children compare with the condition of California children in the past, or with the condition of children in other states, or other countries? Although substantial problems hinder obtaining and interpreting comparative data, such comparisons, *carefully used*, can provide a yardstick for setting goals, for assessing the impact of past social policy, and for judging the quality of public and private programs for children. For example, if children in New York State scored better on the Scholastic Aptitude Test (SAT) than comparable California children, we would want to know why. Such data may also sometimes help us understand the impact of social changes, such as changes in family structure, on the condition of children.

Data comparing the status of subgroups of California's children are especially important to the development of public policy. When differences in the condition of children are based on the economic status of their parents, their racial or ethnic background, their place of residence, or the school district they attend, we must ask why. To the extent a subgroup of California children is in worse condition than other groups of children as a result of unequal access to resources, our state's and nation's commitment to equal opportunity requires efforts to reduce or eliminate the inequality.

Data Limitations

In developing this book, we tried to obtain data that would provide a comprehensive picture of the condition of California's children. Unfortunately, even for "basic" measures, such as poverty statistics, finding adequate data turns out to be extraordinarily difficult. We had hoped to find national statistics, statewide data, and breakdowns indicating children's condition *within* subareas of California. We were able to contract with Child Trends, Inc., of Washington, D.C., to provide some interstate comparisons, but often we could not find data distinctions for areas within California. In fact, for some measures there are no statewide data, so we had to estimate the California numbers from national statistics, and had to speculate as to whether California diverges markedly from national trends.

We encountered the same problems that have faced researchers in other states. There is a vast amount of data at a detailed program level but these data do not necessarily illuminate the overall status of children. Moreover, it is difficult to identify data sources because no one compiles a master list of available data. Fortunately, people in state and local agencies went out of their way to make their internal files and data banks available to us. However, information systems are fragmented and, not surprisingly, primarily responsive to the needs of individual agencies.

It is especially difficult to put together a picture of children that tells us something about the whole child. For example, we may be able to report the number of children with substantial health problems who come to the attention of public health agencies and the number of children failing in school, but we cannot tell how many children are experiencing difficulties in both domains (and, of course, the condition of any given child depends on how he or she is doing in a variety of domains). Moreover, because most government programs focus on children with relatively serious problems, we know little about children who do not show such problems.

Data concerning the *condition of children's service systems* are a great deal more precise than data about the *children* within those systems. We know about the occupancy statistics in the Youth Authority (for example, two youths to a cell) but we have no data on what daily life is like in an overcrowded jail. We know about

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the number of children per worker in a child care facility, but we can only speculate about how children experience underfunded child care. We know the number of children reported to be abused and neglected and the number of workers assigned to protect them, but we know little about the condition of the children when they enter the system, their condition when they leave the system, or what it is like to live in a foster home.

In some areas, the gaps are especially great. We know very little about the well-being of children aged 1 to 4. They generally are not seen by the health care system, they have not entered the school system, and the child care system does not generally gather data about children's conditions. And while the private sector provides an enormous amount of services to children—for example in sports, scouting, and church—private agencies are not organized or financed to collect data broadly.

Implications of Data Limitations

Even those data that are collected may be of limited reliability and utility because of constantly shifting definitions of key measures, changing rules regarding the type of data to be reported, and changing degree of rigor in gathering data (which often depends on fluctuating staff size).

It is important for policymakers to recognize these problems in our methods of gathering data because such problems significantly limit our ability to perform sound policy analysis. We have been unable to interpret the trend data with regard to many of the measures we examined. For example, if the way of defining or assessing a given measure (such as physical abuse or learning disability) is changed over time, the prevalence of a condition may appear to change over time when no actual change has occurred. As a result, we cannot tell whether the situation is getting better or worse; nor can such data be used as a means of evaluating programs or assessing the impact of changing social conditions. For example, a reduction in abuse reports may be used to measure the success of an abuse prevention program. However, if the definition of abuse has changed during the life of the program, changes in the number of reports over time would not be a meaningful indicator of the program's impact.

It should be emphasized that even without such problems trend data must be used very cautiously, particularly when they are used to "demonstrate" the impact of broad social changes, such as an increase in divorce or in work force participation by mothers. Trend data often are used to prove a commentator's favorite thesis about why a certain trend has taken place. For example, it might be asserted that declining test scores during a period of increased school expenditures demonstrate that the expenditures were useless or spent unwisely. Yet many other possible explanations for the decline may be possible. There may have been a change in the composition of the school population (for instance, an increase in the percentage of non-English-speaking children who may do poorly on such tests). Similarly, changes in the number of crimes committed by minors may be due to more (or fewer) minors in the general population, not to the alleged positive effects of a prevention program or the alleged negative effects of an increase in divorce.

We have chosen these specific examples because they illustrate one of the most common failures in policy analysis—the failure to understand the policy implications of major changes in the composition of the general population. Many social conditions are highly related to such crucial population variables as age distribution; income, racial, and ethnic composition; and percentage of immigrants in the general population. Used carefully, trend data can provide important insights into the likely reasons for some changes in the conditions of children. But unsophisticated use of such data often leads to poor policymaking.

Improving Data Collection

Some states, such as New York, have specific state agencies charged with compiling and analyzing data on children's services.

California has no such agency and no plans to establish one. No state policy evidences concern about understanding the overall condition of children. At the same time, many politicians note the state's large investments in services for children. It is important, however, to know more than what we spend—we need to know the impact of these expenditures. We want to know: do our schools teach our children to read? Do our health services keep them healthy? Are we able to protect children and their families from harm? Are we doing better or worse than five, ten, or twenty years ago? These questions are not easy questions to answer. As a start, we must establish a system for collecting a usable set of social indicators of the condition of California's children.

Conclusion

Throughout this report, we primarily present facts about the condition of children. To a more limited degree, some chapters also propose criteria for assessing these facts—that is, goals for the well-being of children against which their current status can be measured. In addition, some policy initiatives are suggested.

We hope that this report will enable those concerned with the status of children and families to construct appropriate policies. However, the facts presented in this book are merely tools for analysis. Ultimately, all public policies that seek to improve the well-being of children must be based on values as well as on facts. Beyond some minimum levels, what it means to be healthy, educated, well-cared for, and so on is a question of values, not facts.

We have not, as a state or as a nation, developed a public consensus regarding the quality of life our children should be able to expect—with regard to parental care, health status, care in settings outside the family (such as day care, foster homes, and residential placements), education, or quality of neighborhood and general environment. Unlike adults, children do not have (even theoretically) the capacity to control the quality of their lives. Their well-being and their day-to-day happiness are controlled by others—parents, teachers, and so forth. Moreover, their capacity to become happy and self-sufficient adults is heavily influenced by what is done to them, and for them, during childhood. What are the implications of this total dependence of children on adults? What commitment of public resources, if any, are children "entitled" to? We hope that this book will encourage readers to confront these questions.

Chapter 2

A Sociodemographic Portrait

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We begin our description of the conditions of children in California by looking at some broad trends regarding the number, age distribution, and racial and ethnic background of California's children. Too often, public discussion about the well-being of children and about children's services pays scant attention to the implications of major demographic shifts. Heading into the twenty-first century, California's children will be a growing and increasingly heterogeneous population in terms of race and ethnicity, immigrant status, language and culture, and family arrangements, among other factors. In order to understand the conditions of children, we must first understand the magnitude, direction, and sources of these changes. Therefore, in this and the next two chapters, we examine the broad trends affecting children[1] and look at how the children and their immediate environments are changing.

It is common to think of the condition of children in terms of individuals; it is certainly true that the well-being of each child is related to many factors specific to that child, such as the care the child receives from family, child care providers, and teachers. However, the conditions of individual children, and children *as a group* (compared with other segments of the population), are affected by factors that are part of the larger environment in which children and families live; such factors may be political, economic, or demographic. Population trends are especially important: the size and composition of the child population as a whole affects all children in such things as their access to public and private resources, and their likelihood of finding employment, and influences the degree to which the well-being of children assumes importance on local and state political agendas.

Adequate planning requires an understanding of how the child population is likely to change over time. A view over time enables us to note when children born in a single or in proximate years (called a *cohort*) will begin to use services from private and public institutions, such as schools and youth organizations; hence, a view over time enables us to consider the capacity needs of these organizations. Factors to consider include when the cohort will pass through ages of varied risk (such as age-linked periods of higher rates of juvenile crime or substance abuse), when that cohort will begin to enter the labor market, and so forth. These trends must be looked at both in terms of the entire state population and with regard to particular regions, counties, or communities, because the demographic characteristics of different areas vary significantly.

The Basic Numbers

As of March 1988, approximately 7.567 million children were living in California. By the year 2000, this number will rise to 8.7 million, a 16 percent increase, but a 36 percent increase since 1980 (Table 2-1). Over the next ten years California's families, communities, institutions, and public budgets will have to accommodate an additional 1.4 million children.

Not only will more children be living in California, but the children of California will comprise an increasing proportion of the nation's children. At present, one in every nine children in the United States lives in California. By the year 2000, that proportion will rise to one in every eight. Their well-being will significantly affect the nation's well-being. California children comprise an even more substantial proportion of the nation's minority[2] children (Table 2-2). Recent estimates suggest that Hispanic children in California comprise about one in three (35 percent) of all Hispanic children in the country. Children in California of Asian and Pacific Islander descent comprise about one in three (over 30 percent) of all Asian children nationwide. California children of Native American descent are about one in seven (14 percent) of all such children. In contrast, California's black children are only about one in sixteen (6 percent) of all black children in the country. Non-Hispanic whites in California are about one in eleven (9 percent) of all non-Hispanic white children nationwide.

TABLE 2-1 Children in California, Trends and Comparisons, 1970-2000 (in thousands)

	1970	1975	1980	1985	1988	1990	1995	2000
Total population (all ages)	20,039	21,537	23,775	26,365	27,857	28,771	30,956	32,853
Number of children (ages 0–17)	6,549	6,432	6,419	6,988	7,567	7,701	8,431	8,666
as percent of state total	32.7	29.9	27.0	26.5	27.2	26.8	27.2	26.4
Percent change since 1970								
in total population	—	7.5	18.6	31.6	39.0	43.6	54.5	63.9
in child population	—	–1.8	–2.0	6.7	15.5	17.6	28.7	32.3

SOURCE: California Department of Finance. Current Population Survey, California State Data Census Center Summary, 1986–1988.

TABLE 2-2 Children by Race and Ethnicity, California and the Nation, 1988 (in thousands)

	Total	White	Hispanic	Black	Others
United States	63,478	44,602	6,827	9,639	2,411
California	7,567	3,873	2,385	543	765
as percent of U.S.	11.9	8.7	34.9	5.6	31.7

Note: "Other" includes children of Asian, Pacific Islander, Native American, Aleut, Eskimo, and other descent.

SOURCE: PACE calculations from Current Population Survey, California State Data Census Center Summary, 1988.

Population Dynamics

The increase in the number of children since the late 1970s is in marked contrast to the recent past. In fact, between 1970 and 1980 the number of children in California actually decreased, from approximately 6.55 million to 6.42 million. Since the late 1970s, however, the number of births and the number of children overall have been increasing. Changes in the size of a child population over time reflect the effects of three factors in particular: fertility patterns, the number of women of childbearing age, and levels of immigration.

The decline in the number of children in California during the 1970s was due primarily to the decline in fertility rates (the number of children born per 1,000 women ages 15–44). During the late 1960s and early 1970s, women of childbearing age were choosing to have fewer children (Table 2-3). This decline followed the long-term trend that began in the late 1800s, but was interrupted briefly by increased fertility rates immediately after World War II and through the mid-1960s (the "baby boom").

TABLE 2-3 California and National General Fertility Rates among Women, 1950–1986

	California	United States
1986	74.8	64.9
1985	74.6	66.1
1984	72.4	65.4
1983	71.7	65.8
1982	72.0	67.3
1981	71.9	67.4
1980	70.4	68.4
1979	68.9	67.2
1978	66.6	65.5
1977	67.2	66.8
1976	66.1	65.0
1975	65.1	66.0
1974	65.9	67.8
1973	64.8	68.8
1972	68.4	73.1
1971	75.4	81.6
1970	84.7	87.9
1965	92.7	96.3
1960	115.7	118.0
1950	101.5	106.2

Note: General fertility rate is the total number of live births, regardless of mother's age, per 1,000 women of childbearing age (15–44).

SOURCE: California Department of Health and Human Services, *Vital Statistics of California, 1986* and *Vital Statistics of California, 1970*. National Center For Health Statistics, *Advance Report of Final Natality Statistics, 1985*. Monthly Vital Statistics Report, Volume 36, No. 4, July 1987.

The increase in the number of children beginning in 1980 reflects a small increase in the fertility rate. In this, California differs from the nation as a whole, for which there has been no increase in fertility. As we discuss later, the higher fertility rate in California is probably accounted for by the higher proportion in the female population of women of childbearing age from ethnic groups with high fertility rates. Even with the recent slight overall increases, the fertility rate remains well below pre-1970 rates. Women of every racial and ethnic background are having fewer children than in the past (Table 2-4). The main reason for the rise

TABLE 2-4 Cumulative Fertility Rates by Ethnicity and Age, 1970 and 1980

	Fertility Rate by Ethnicity				
	White	Asian	Black	Hispanic	All
Women Ages 15–24					
1970	317	262	483	490	357
1980	227	168	454	496	304
Women Ages 25–34					
1970	1,879	1,648	2,327	2,450	2,000
1980	1,160	1,112	1,630	1,940	1,344
Women Ages 35–44					
1970	2,623	2,591	3,149	3,531	2,801
1980	2,253	2,212	2,859	3,233	2,480

Note: Cumulative fertility rate equals births per 1,000 women.

SOURCE: U.S. Bureau of the Census, *U.S. Census of Population for California*, 1970 and 1980. McCarthy and Valdez, *California's Demographic Future*, The Rand Corporation, 1986.

in the number of births is that the number of women of childbearing age in the general population has increased substantially in the 1980s, as the "baby boom" generation of the 1950s reached peak fertility years (Table 2-5). Even though women in this generation are having fewer children than their parents, the sheer size of the baby boom generation means that the total number of births is increasing. This growth is an example of how the behavior of one generation affects the conditions of a second and third generation, even when the behavior of the later generations changes considerably.

California's child population also is growing because of immigration into California. Prior to 1970, most newcomers came from other states. Since 1970, immigration has been primarily from other countries; in fact, internal migration now takes away

TABLE 2-5 Women of Childbearing Age (15–44) in California, 1965–2000 (in thousands)

1965	1970	1975	1980	1985	1990	1995	2000
3,828	4,285	4,872	5,692	6,308	6,661	6,840	7,049

SOURCE: California Department of Finance, Population Research Division, *Population Projections.* U.S. Bureau of the Census, *U.S. Census of Population for California*, 1970 and 1980.

TABLE 2-6 California Population Growth, 1900–1980: Total Change and Components of Change by Decade

		Total Change		
Decade	Total Growth	California Born	Other U.S. Born	Foreign Born
1900–1910	60.1%	27.2%	48.3%	24.7%
1910–1920	44.1	34.7	49.1	16.2
1920–1930	65.7	29.7	56.3	14.0
1930–1940	21.7	48.1	63.8	–12.0
1940–1950	53.3	37.2	58.3	4.5
1950–1960	48.5	46.6	48.6	4.8
1960–1970	26.9	55.1	35.0	9.9
1970–1980	18.6	56.6	–5.6	49.0

SOURCE: U.S. Bureau of the Census, *U.S. Census of Population for California*, 1960, 1970, and 1980. McCarthy and Valdez, *California's Demographic Future*, The Rand Corporation, 1986.

more people than it adds (Table 2-6). Immigration increases the child population immediately, because many immigrants are children. It also affects future population trends since immigrants add to the size of the childbearing population and recent immigrants tend to have higher fertility rates. If low fertility among the domestic population persists (the consensus from recent research), foreign immigration– legal and illegal– will account for an increasing share of total population growth. And if recent trends in immigration continue, projected declines in births by native born mothers (as the childbearing cohorts decrease in size) will be offset by increases through immigration. Foreign-born children and children born to recent immigrants will comprise an increasing percentage of the total child population.[3]

It is difficult to determine the exact number of immigrants who come to California each year. The Immigration and Naturalization Service asks immigrants where they *intend* to settle; once in the United States, they may move, although settlement patterns among past and recent immigrants suggest that intended location is often the actual one. Estimates based on data about the *intended* state of residence provide some indication of the California share. Beginning in 1966, as a result of a new immigration law, the number of immigrants to the United States increased dramatically (Table 2-7 and Figure 2-1). Since 1975, approximately 500,000 documented immigrants have entered the United States annually.[4] In recent years, over 25 percent of all immigrants, between 140,000 and 150,000 per year, have settled in California, at least initially. On average, between 25 and 30 percent of these immigrants have been children, although this percentage varies by group, source country, and conditions of immigration (refugee status, family reunification, and so on).

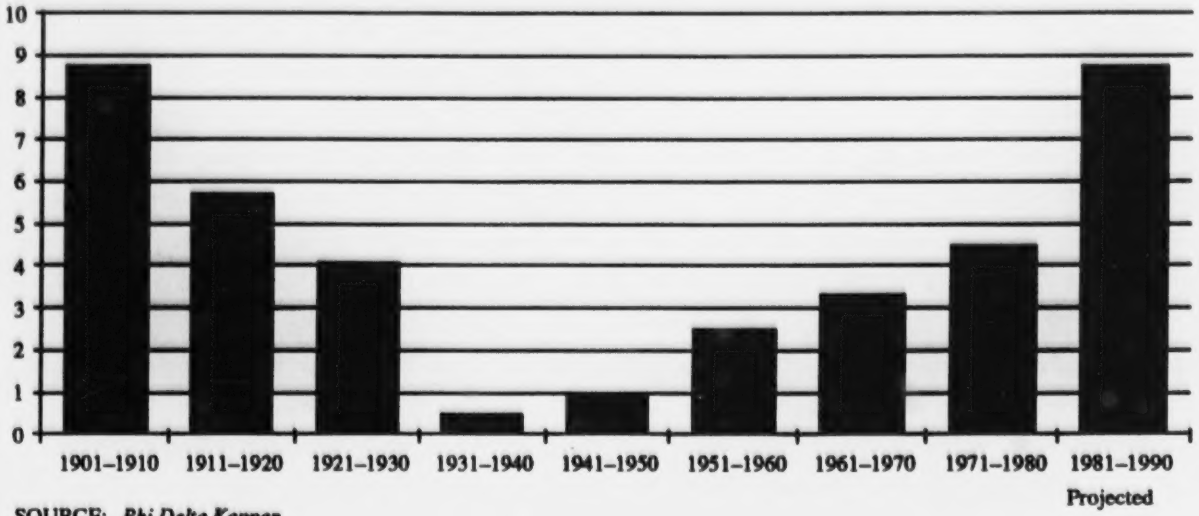
TABLE 2-7 Immigrants to the United States and California, 1976–1986 (in thousands)

	1976	1979	1982	1983	1984	1985	1986
U.S.	502	460	594	560	544	570	602
California	114	119	163	135	140	155	169
California as percent of total	22.7%	25.8%	27.4%	24.1%	25.8%	27.3%	28.0%

Note: Figures are for legal immigrants who state California as their intended residence at admission.

SOURCE: U.S. Immigration and Naturalization Service, *Statistical Yearbook of the Immigration and Naturalization Service, 1986.*

FIGURE 2-1 Legal Immigrants to the United States, by Decade



SOURCE: *Phi Delta Kappan.*

Household Composition

An increase of 1.4 million children obviously has major implications, for the children themselves and for policymakers. Public and private resources will have to accommodate a larger number of children. Without new resources, the amount available to each child will decline.

However, while the child population is growing rapidly, the size of the adult population is increasing even more rapidly (Table 2-1). Although the number of children in California will have increased by 32 percent between 1970 and 2000, the number of adults will have increased by 64 percent.[5] In 1970, children comprised 33 percent of the entire population. Today, they comprise just over 26 percent; this figure will remain relatively constant through the year 2000, even as absolute numbers of children are increasing. This figure— children as about one-fourth of the population— is somewhat lower and more stable than over the past several decades, but also varies across race and ethnic populations.

Thus, there are now many more adults available to help provide for the needs of our children— provided these adults are able and willing to invest resources in children. In this regard, it may be relevant that the percentage of households containing children is declining. In 1960, approximately 50 percent of all California households contained children; today that figure is down to 38 percent (Table 2-8). This trend reflects the fact that there has been some decline in percentage of people who ever

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TABLE 2-8 California Households, by Type and Presence of Children, 1960–1988 (in thousands)

	1960	1970	1980	1985	1988
Households	4,980	6,572	8,645	9,391	10,183
Families	80.1%	75.8%	69.2%	68.6 %	70.2%
Without children	34.1	33.4	33.5	30.3	32.0
With children	46.0	42.4	35.6	38.3	38.2
Married couple	41.4	35.7	27.9	29.7	29.0
Single parent	4.6	6.7	7.8	8.7	9.2
Female	4.0	5.8	6.6	7.0	7.3
Male	0.6	0.9	1.2	1.7	1.9
Nonfamilies	19.9	24.2	30.8	31.4	29.8
Persons living alone	15.0	18.0	24.6	25.3	23.2

SOURCE: McCarthy and Valdez, *California's Demographic Future*, The Rand Corporation, 1986. State of California, Employment Development Department, *Socio-Economic Trends in California, 1940–1980*, 1986. Current Population Survey, California State Census Data Center Summaries, 1985 and 1988.

marry, some increase in percentage of childless couples, and substantial change in total household composition, including a greater percentage of older couples and individuals living alone. The future well-being of California's children may depend not only on the resources their parents provide them but on the willingness of people who do not have children to provide both time and money to children.

Age Structure of the Child Population

Size alone tells only part of the story—age distribution also is important. Despite overall increases in the child population, the number of youths in their late teens is still declining even as the number of infants and young children is growing. These larger, younger cohorts will move through the years of childhood, dramatically shifting the numbers of children in particular age groups and the proportion of the child population accounted for by very young children, by school-age children, and so forth.

As the data in Table 2-9 show, the proportion of the child population under 6 years old and then under 15 will be changing quite substantially through the year 2000. The number of children in the 0–5 age range, which has been increasing steadily since 1975, will peak in 1990 at 2.77 million and then begin to decline gradually; this profile reflects the decline in the number of women of childbearing age in the population. In contrast, the number of

TABLE 2-9 Trends and Projections in the Age Composition of California's Child Population (Ages 0–17), 1970–2000

	1970		1975		1980		1985		1990		1995		2000	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Ages 0–5	1,975,634	30.2	1,935,226	30.1	2,038,552	31.8	2,650,387	37.9	2,766,620	35.9	2,728,102	32.4	2,649,232	30.6
Ages 6–14	3,469,726	53.0	3,275,856	50.9	3,140,210	48.9	3,198,101	45.8	3,885,791	50.5	4,426,654	52.5	4,480,187	51.7
Ages 15–17	1,103,167	16.8	1,220,613	19.0	1,239,920	19.3	1,140,004	16.3	1,048,614	13.6	1,276,346	15.1	1,536,520	17.7
TOTAL	6,548,527	100	6,431,695	100	6,418,682	100	6,988,492	100	7,701,025	100	8,431,102	100	8,665,939	100

SOURCE: California Department of Finance.

children ages 6–14 will rise by 40 percent between 1985 and 1999, increasing from 3.2 to 4.5 million. The number of children ages 15–17 will not begin to show increases until the early 1990s, but will continue to increase into the early part of the twenty-first century.

In sum, larger birth cohorts from the late 1970s and contributions from immigration are currently enlarging the youngest age groups. In coming years, these larger cohorts will gradually increase the overall child population. By the early 1990s, the youngest age groups may begin to decrease in size (as childbearing cohorts decrease and if fertility levels remain the same), even as the number of teenagers continues to increase for some time.

Race and Ethnicity

It is impossible to understand California, and the condition of its children, without understanding the diversity of groups that comprise the total population. California is the most racially and ethnically diverse state in the country. In 1985, over 40 percent of California children were Hispanic (30.5 percent) and Asian (9.7 percent).[8] Black children comprised about 9 percent of the California child population. The proportion of minorities in the child population has been growing steadily, quickening in the last ten years (Table 2-10). The racial and ethnic composition of California's child (and adult) population differs markedly from that of the rest of the nation, and from the other large, urban states (Table 2-2 and Figure 2-2). Asian and Hispanic children comprise a considerably larger percentage of California's children than the nation as a whole; black and white children comprise smaller segments of California's child population than in the nation as a whole.

By the year 2000, it is projected that half the children in California will be Hispanic (36 percent) or Asian (13 percent). The proportion of black children is likely to remain about the same. "Majority" whites—that is, non-Hispanic whites—comprise a steadily decreasing proportion of the child population. To a large degree, these trends in the racial and ethnic composition of California's child population reflect the effects of changing immigration patterns and differences in fertility rates among various ethnic and racial groups. As noted earlier, fertility rates have fallen since the early 1970s among virtually all age, race, and

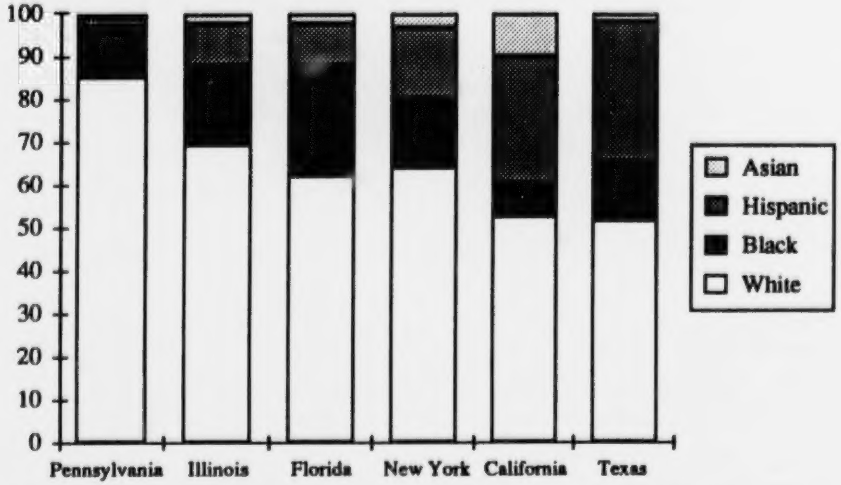
TABLE 2-10 Actual and Projected Composition of California Child Population, by Race and Ethnicity, 1976–2000

	1976	1980	1985	1990	1995	2000
White	61.1%	56.2%	50.8%	46.8%	44.3%	42.2%
Hispanic	22.3	27.4	30.5	33.2	34.5	35.5
Black	10.0	9.2	9.0	8.9	9.1	9.1
Other	6.6	7.2	9.7	11.0	12.1	13.0

Note: Racial and ethnic categories sum to 100 percent. Although Hispanic persons may be of any race, this count uses exclusive categories. Hence, earlier population data is not comparable. "Other" includes those of Asian, Pacific Islander, Native American, Eskimo, and Aleut descent. Asians comprise the largest and fastest growing component of this category.

SOURCE: Current Population Survey, California State Census Data Center Summaries, 1976 and 1985. California State Department of Finance.

FIGURE 2–2 Ethnic Composition of the Child Population (Ages 0-17) in Six Large States, 1985–86



SOURCE: Child Trends, Inc., compiled from Current Population Surveys, 1985 and 1986.

ethnic groups, and are expected to remain low in future years. However, these rates began to decline earlier and fell more steeply among nonminority than among minority women, and, within each ethnic group, among better-educated than among less well-educated women. Although fertility rates have now fallen among minority as well as nonminority women, Hispanic rates remain somewhat higher, resulting in continued fertility differentials among various ethnic and racial groups in the state (Table 2-4).

Due to changing immigration patterns, the child population is becoming more heterogeneous, even within racial and ethnic groups. The population that is labeled Hispanic or Asian for statistical purposes increasingly represents a larger number of source countries, cultures, and ethnic groups. For example, recent immigrants from Southeast Asia add considerably to the diversity of the California population of Asian heritage, tending to have sociodemographic characteristics quite different from the more established domestic populations of Chinese, Filipino, Japanese, and Korean descent. Similarly, immigrants from Central American countries have diversified the Hispanic population.

In summary then, the higher rates of increase among nonwhite populations due to higher fertility and immigrations, particularly among the nonblack minority groups, means that even though the total *number* of white (and all) children is growing, a growing *proportion* of the child population will be of Hispanic or Asian descent.

Age Structure of Ethnic Groups

The various racial and ethnic minority groups in California tend to be "younger" populations, with children (and young adults) comprising a higher proportion within each group than do children in the overall state population. A group with a "younger" age structure—that is, with proportionately more people in the younger ages—has intrinsically what demographers refer to as "population momentum." A group with more people in or entering the prime childbearing years will generate a greater number of births, assuming approximately constant fertility rates over time. Thus, as a result of varying age-at-immigration patterns, fertility rates, and longevity, current differences in the age structures of various groups will result in continued shifts in the demographic mix.

Location of Children

Although it is important to examine broad trends in the age structure and racial and ethnic composition of the child population across the state, it is also crucially important to take note of local jurisdictions that are experiencing quite distinct demographic trends. Public services that affect most children in the state tend to be organized in terms of local jurisdictions—counties, cities, and school districts. In addition, as other chapters suggest, the immediate environments of most children are families, neighborhoods, and local communities. Hence, it is worthwhile to consider the distribution and concentration of children by such jurisdictions. Such data as are available underscore the widely varying profiles of the child population in different localities.

Urban Status

California children are a highly urbanized population, concentrated in cities and suburbs, as is the adult population (Table 2-11). In 1980,[7] 91 percent of all children were residents of urban areas, 32 percent in central cities alone.[8] Such urban status varied across racial and ethnic populations. Minority children, especially blacks, tend to be the most highly urbanized, especially concentrated in central cities; although some new patterns of minority suburbanization are occurring. Non-Hispanic white children remain the least urbanized and the least likely to live in central cities. In the central city child population, white and Hispanic children each comprise about 30 percent; Asians and others about 25 percent; and blacks 15 percent. Among the much smaller rural child population, whites are nearly 63 percent, followed by Hispanics at 21 percent.

TABLE 2-11 Urbanization of California Children, Overall and by Race and Ethnicity, 1980

	Percent Urban Overall	Percent in Urban Central Cities	Percent Rural
Total children	90.8%	32.2%	9.2%
White	86.6	22.4	13.4
Black	98.9	58.1	1.1
Hispanic	93.2	34.7	6.8
Other	93.1	38.7	6.9

SOURCE: U.S. Bureau of the Census, *U.S. Census of Population for California*, 1980. McCarthy and Valdez, *California's Demographic Future*, The Rand Corporation, 1986.

County Child Populations

County child populations vary in size (Appendix Table 2-1). Almost one-third of all California children live in Los Angeles County alone—2.2 million children, more than the child populations of over forty other states and more than the total population of twenty states! More than half of all California children live in the area in and around Los Angeles, and over 70 percent live in the ten largest counties. Current projections indicate that this distribution is likely to remain stable in the foreseeable future (Table 2-12).

Children comprise substantially different proportions of county populations generally, ranging from highs of between 30 and 38 percent throughout the San Joaquin Valley counties to lows of about 18 percent in San Francisco, Marin, and Alpine Counties (Appendix Table 2-2). Significant changes will likely occur in the absolute size of child populations in various counties over the next decade. Many suburban and rural counties will experience rapid increases in currently small child populations—between 30 and 50 percent more children by 1995 (Appendix Table 2-3). Because the number of children in some of these counties is relatively small at present, limited services and resources may be available to children there. Some large counties will show only slight percentage increases, but these will represent tens of thousands of youngsters.

County figures may obscure substantial variation between particular communities or neighborhoods. Nevertheless, these numbers provide a dramatic summary of the kind of variation that has implications for children's access to various kinds of public resources and more symbolically to the political currency their special needs engender.

TABLE 2-12 County Children as a Percentage of All California Children, 1985 and Projected 1990 and 1995

		1985	1990	1995
1	Los Angeles	31.9%	32.1%	31.1%
2	Orange	7.8	7.5	7.5
3	San Diego	7.6	7.6	7.8
4	Santa Clara	5.1	4.8	4.7
	SUBTOTAL	52.4%	52.0%	51.1%
5	San Bernardino	4.6%	4.9%	5.2%
6	Alameda	4.3	4.2	4.1
7	Sacramento	3.3	3.3	3.4
8	Riverside	3.2	3.5	3.8
9	Contra Costa	2.6	2.5	2.5
10	Fresno	2.5	2.6	2.6
	SUBTOTAL	72.9%	73.0%	72.7%
	All others	27.1%	27.0%	27.3%
	TOTAL	100.0%	100.0%	100.0%

SOURCE: California Department of Finance, Projections 1980–2020.

City Child Populations

A more fine-grained look comes from considering children in cities. As noted, children from racial and ethnic minority groups are more likely to be metropolitan and more often live in the central city than do children overall. (More than other minority children, Hispanics may live in the country.) Several California cities are among a relatively few cities in the nation with substantial proportions of three and even four racial and ethnic groups– such that the white share is not the second but perhaps only the third or fourth largest group in the community (Table 2-13). The presence of two or more substantial but distinct (and often separated) minority populations in a city suggests the emergence of new and more complex challenges for public officials and private citizens. Such "tri-" or "quadriethnic" communities as San Francisco, Oakland, and other cities represent prototypes of a multiracial, multiethnic California of the not too distant future.

TABLE 2-13 Racial/Ethnic Composition of Child Population in the Ten Largest California Cities, 1980

	Total	White	Black	Hispanic	Other
Anaheim	58,168	68%	1%	24%	6%
Fresno	60,912	50	13	34	4
Long Beach	82,638	48	18	24	10
Los Angeles	745,738	32	20	40	8
Oakland	82,492	17	60	14	10
Sacramento	67,784	48	19	22	11
San Diego	211,432	54	12	23	11
San Francisco	126,755	26	18	18	30
San Jose	195,285	56	5	29	10
Santa Ana	62,326	28	4	59	9

SOURCE: U.S. Bureau of the Census, *U.S. Census of Population for California*, 1980.

Conclusion

These demographic trends pose a number of crucial issues for policymakers, educators, and the public. The shifting size of various age groups means that there will be a 33 percent increase in the number of high school age students, with a corresponding need for increased services. More recreational activities and more places in youth organizations will also be needed. These figures also indicate that the number of young adults entering college and seeking employment will increase substantially, requiring an ever-expanding economy if we are to limit unemployment.

The remarkable racial, ethnic, and linguistic diversity of California's population is a great strength of the state. It also poses a great challenge. As the following chapters demonstrate, the condition of different ethnic and racial groups varies considerably. Most significantly, nonwhite children are much more likely to be poor. The significant group differences in family structure, fertility rates, and educational backgrounds all are related to family income and other aspects of a child's well-being. The condition of California's children will be heavily affected by how well public and private institutions respond to the increasingly varied cultural backgrounds of California's children.

Chapter 3

Family Life

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Claire Smrekar
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Our society places primary responsibility for ensuring a child's well-being on the child's family.[1] We expect families to provide children with shelter, food, and clothing, to teach them basic skills and values, and to nurture their emotional development. The family also serves as a link between children and institutions and services, such as schools, health care services, and recreational and cultural facilities. Society as a whole tries to guarantee that all children receive certain basic goods– schooling and a minimum level of shelter, food, and safety. However, if parents are unable or unwilling to invest heavily (in terms of interest and commitment) in the growth of their children, their children's well-being will suffer.

Because the role of families is so crucial, evidence indicating how well families are functioning may provide an important indicator of the general well-being of children. At the extreme, inappropriate or inadequate care amounting to abuse or neglect clearly damages many children. (We discuss the growing incidence of abuse and neglect in Chapter 10.) However, in the absence of evidence of abuse or neglect it is difficult to draw many conclusions about the conditions of children on the basis of information about their families. Although there is consensus that family is important, people disagree considerably about *what* aspects of family are important. A substantial body of scholarship indicates that the nature of "family processes" (such as parental love and attachment to children, and the nature of parent-child, parent-parent, and sibling interactions) greatly influence a child's emotional well-being, academic performance, and social behavior.[2] But family processes are exceedingly complex. There is not one "correct" means of child rearing. These processes often vary depending on a family's racial, ethnic, or cultural background, as well as on the parents' education, social background, and income. We do not know whether particular patterns of parental behavior have different effects on children of varying cultural or social backgrounds.

Moreover, no systematic body of data provides a picture of the ways most families interact with their children, even for those aspects of family interaction that might serve as good proxies for children's well-being. In fact, for the reasons discussed in Chapter 1, obtaining such data for large samples of children on a regular basis would be exceedingly difficult. Thus, we cannot present data on the nature and quality of the relationships most children experience in their families, now or in the past.

In the absence of direct measures of parent-child interaction, we can look for other indicators of family functioning that may tell us something about the condition of children. Three elements of a child's family ecology are commonly thought to be relevant to children's well-being, and for these we do have good statistics. These elements are family structure, teenage parenthood, and work force participation by mothers.[3]

We focus on these particular factors for several reasons. First, it is important that policymakers recognize the great variety of family environments in which children live, regardless of the impact of particular types of family environments on children's development. As a result of the increase in divorce, unmarried motherhood, alternative parenting arrangements, and the percentage of mothers in the work force (as well as in the number of immigrant families, who often live in extended family groups), more California children live in more diverse family settings than at any time in recent decades. Yet, until quite recently, many public and private programs– in fact, most societal institutions that serve children and families– were structured on the assumption that most children lived with two biological parents, one of whom worked outside the home (the father) and the other of whom was a full-time housekeeper (the mother). Such families now constitute only a small proportion of all families with children.

Second, we look at these aspects of family life because it is widely believed that changes over the past twenty years related to these elements of family life have made the condition of children in California worse. In particular, people are concerned that divorce, single parenthood, unmarried motherhood, and teenage motherhood are harmful to many children. Some also express concern over work force participation by mothers.[4] We therefore try to summarize what is known about the prevalence of these arrangements and about the impact on children of these aspects of family life.

This chapter looks at the relationships between family structure, parental age, and children's well-being. Although limited, the available evidence does suggest that parental divorce, being raised by a single parent, or being born to a teenage mother increases the risk that a child will experience problems in academic, emotional, and social development. Thus, it is not unreasonable to treat the numbers of divorces, the number of births to unmarried mothers, and the number of children born to teenage mothers as indicators of, or proxies for, the condition of children. But it must be remembered these indicators are rough at best; many children do well in every type of family structure, and with younger as well as older parents.

We address the issue of the mother's work force participation in Chapter 5. To summarize its conclusions: we cannot tell much about the condition of a child solely on the basis of whether the child spends time in care outside the home; the impact of mothers' work force participation seems to be highly related to the quality of available child care.

We begin here by describing the trends in divorce rates, fertility patterns among unmarried women, and births to teenage mothers. We then discuss the impact of these parental behaviors on the condition of children.

Changes in Family Structure

Children today live in family arrangements very different from those surrounding children twenty or thirty years ago. The change has affected virtually all groups of children; it is especially powerful for black children.

The basics are now well known. First, general household size has gotten smaller. In 1980, 77 percent of all California families with children under age 18 had one or two children, while 23 percent had three or more.[5] In contrast, in 1970, 66 percent of such families had one or two children; 3[illegible] percent had three or more (Table 3-1). The percentage of families with more than three children has declined even more dramatically, from approximately 16 percent to 8 percent.[6] There is substantial variation by ethnicity and race (Table 3-2). As reported in Chapter 2, black, Hispanic, and Southeast Asian families tend to have more children than others.

Second, the number of children living in California households headed by at least one of their own parents has decreased, although more than 90 percent of all children still live with one or both parents. In 1970, approximately 5.5 percent of children lived in families headed by relatives or foster parents; the percentage was 8.5 in 1980 (Table 3-3).

TABLE 3-1 Presence and Number of Children in California Families, by Family Type, 1970 and 1980 (numbers in thousands)

	1970	1980
Families	5,001	5,978
Without Children	44.1%	48.5%
With Children	55.9	51.5
1 child	33.6%	40.4%
2 children	32.0	36.8
3 children	18.7	15.1
4+ children	15.6	7.7

SOURCE: U.S. Bureau of the Census, *U.S. Census of Population for California*, 1980.

TABLE 3-2 Presence and Number of Children in California Families, by Family Type and by Race/Ethnicity, 1980 (numbers in thousands)

	White		Black		Native American		Asian and Pacific Islander		Hispanic	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
No children	2,482	52.2%	159	36.9%	20	36.4%	119	40.2%	297	30.4%
Families with children	2,271		272		34		176		680	
1 child	946	41.7%	114	41.9%	13	38.2%	66	37.5%	225	33.1%
2 children	861	37.9%	90	33.1%	12	35.3%	65	36.9%	222	32.6%
3 children	325	14.3%	43	15.8%	6	17.6%	30	17.0%	129	19.0%
4+ children	139	6.1%	25	9.2%	3	8.8%	15	8.5%	104	15.3%
Married couples										
With children	1,823		142		23		155.6		536	
1 child	707	38.8%	55	38.7%	8	34.8%	56	36.0%	164	30.6%
2 children	715	39.2%	50	35.2%	9	39.1%	59	37.9%	178	33.2%
3 children	279	15.3%	24	16.9%	4	17.4%	27	17.4%	106	19.8%
4+ children	122	6.7%	13	9.2%	2	8.7%	13.6	8.7%	88	16.4%
Female-headed household, no husband present	602		157		12		32		167	
With children	372		116		9.1		17		118	
1 child	191	51.3%	51	44.0%	4.1	45.1%	8.2	48.2%	47	39.8%
2 children	125	33.6%	36	31.0%	2.9	31.9%	5.4	31.8%	37	31.4%
3 children	40	10.8%	18	15.5%	1.4	15.4%	2.3	13.5%	19.5	16.5%
4+ children	16	4.3%	11	9.5%	0.7	7.7%	1.1	6.5%	14.5	12.3%

Note: Hispanics may be of any race category; counts are not exclusive.

SOURCE: U.S. Bureau of the Census, *U.S. Census of Population for California*, 1980.

TABLE 3-3 California Children Living in Households with Parents and Others, 1950 to 1980 (percentages)

	1950	1960	1970	1980
Living in households with at least one parent	91.3%	94.7%	93.5%	90.7%
Living with other relatives	5.9	3.5	4.5	6.5
Living with nonrelatives	1.0	1.1	1.0	2.0
Other	0.4	0.4	0.3	0.3

Note: Percents do not sum to 100 because of cumulative categories.

SOURCE: U.S. Bureau of the Census, *U.S. Census of Population for California*, 1950, 1960, 1970, and 1980. Current Population Surveys, California State Data Census Center, Summaries, 1985.

Third, an ever-increasing proportion of California children live in single-parent households. In 1960, of those children living with parents, approximately 89 percent lived in households with two parents; by 1985, this had declined to about 75 percent (Table 3-4).[7] Today, approximately one of every five children (20 percent) lives in a household where only the mother is present.[8] In addition, approximately 3 percent of all California children live with a single father.[9] The figures vary substantially by race and ethnic group. Black children are far more likely to live with single parents or with relatives than are other children; only 44 percent of black children in California live with two parents (Table 3-5).[10]

TABLE 3-4 California Children by Household and Family Arrangements, 1960 to 1985 (numbers in thousands)

	1960	1970	1980	1985
Children living in households with at least one parent				
Married couple	88.7	83.1	78.0	74.2
Mother alone	8.7	13.7	17.7	19.9
Father alone	1.3	2.0	3.0	3.0

SOURCE: Paul Ong, Jorge Chapa, Werner Schink, Greg Jones, and Tre Braun, "Socio-Economics Trends in California, 1940-80," Employment Development Department, Health and Welfare Agency, State of California, 1986. Calculations by Child Trends, Inc. from Current Population Surveys, 1985 and 1986.

TABLE 3-5 California Children, by Household, Family Arrangements, and by Race/Ethnicity, 1980 (numbers in thousands)

	White	Black	Hispanic	Asian[a]	Other[b]
Total children	3,568	586	1,769	355	67
Living in households with at least one parent	92.6%	85.1%	88.8%	92.0%	85.8%
Married couple	75.7	43.8	71.2	82.7	59.7
Mother alone	14.1	37.5	14.9	7.5	22.0
Father alone	2.7	3.9	2.8	1.9	4.1
Living with relatives	4.7	11.6	8.4	6.3	9.7
Living with nonrelatives	2.0	2.2	1.9	1.2	3.5
Other	0.3	0.2	0.4	0.1	0.4

[a] Includes Japanese, Chinese, Filipino, Korean, Asian Indian, Vietnamese, Hawaiian, Guamanian, and Samoan.
[b] Includes American Indian, Eskimo, and Aleut.

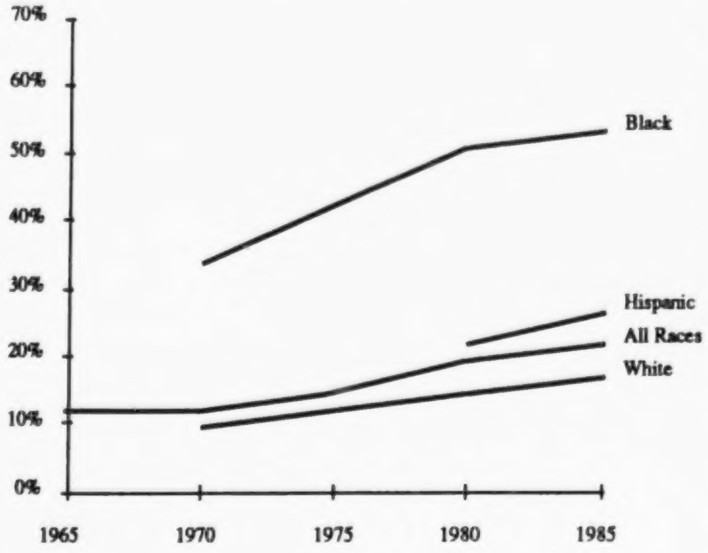
Note: Counts do not sum to total. Percents do not sum to 100 because of cumulative categories.

SOURCE: U.S. Bureau of the Census, *U.S. Census of Population for California*, 1980.

California has approximately the same percentage of children living with single parents as is found in the nation generally (Figure 3-1). The percentage is lower, however, than that in several other large urban states (Figure 3-2). This disparity may reflect the fact that blacks comprise a larger proportion of the population in these states and, as just indicated, the black population has a higher proportion of children living with single parents.

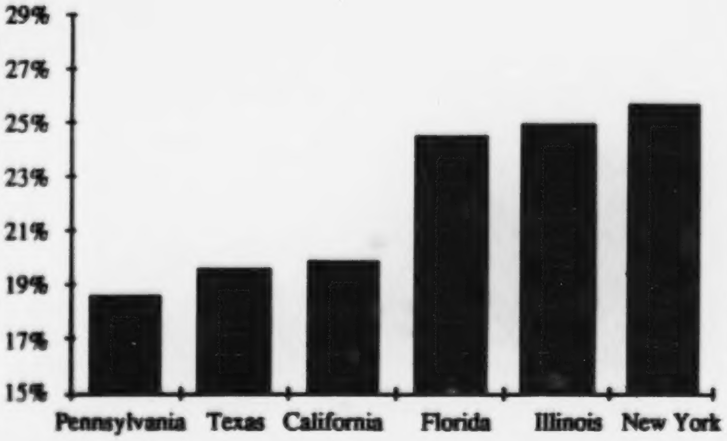
The fact that approximately 75 percent of all children currently live in a two-parent family tells only part of the story; many of these children live with only one biological parent. Because of substantial increases in divorce and remarriage, as well as the fact that many mothers who bear a child outside of marriage ultimately marry someone other than the biological father, the category "married couple family" includes many stepparent families. We cannot provide exact data on the number of children in stepparent families in California from available Census data. We

FIGURE 3-1 Percent of Children Living in Single-Parent Families, in the Nation, by Race of Family Head, 1965 to 1985



SOURCE: U.S. Department of Education, *Youth Indicators*, 1988.

FIGURE 3-2 Percent of Children (0–17) in Six Large States With Mother-Only Families, 1985–86



SOURCE: Child Trends, Inc. from Current Population Surveys, 1985 and 1986.

can, however, estimate the percentage of children living with stepparents with data from several national studies, which examined family structure in large samples of families throughout the nation. From these studies, it appears that, nationally, between approximately 10 and 14 percent of all children living with two parents live with a biological parent and a stepparent.[11] Thus, only 60 to 65 percent of all children presently live with both biological parents.

Perhaps most significantly, *the number of children who will live with a single parent at some point in their childhood is considerably higher than the number who presently live with a single parent.* So is the percentage of children who will live with stepparents. Many children currently live in a home with two biological parents who will divorce or separate, or where one of the parents will die before the child reaches age 18. We cannot, of course, know the exact percentage of children who will live with a single parent. However, several studies have used sophisticated analyses to estimate the probable percentage. One prominent researcher, using data from the 1980 Current Population Survey, estimated that 50 percent of all children will spend part of their childhood living with only one parent; this study also estimated that the average length of time the child will be in a single-parent home to be six years.[12] Other studies make even higher estimates, as high as 60 and 70 percent.[13]

Reasons for Changing Family Structure

There are two reasons for the change in family structure—an increase in divorce[14] and a rise in the numbers of births to single mothers. The change in the divorce rate (the number of divorces per thousand married women) is the more significant cause.

Divorce. Between 1960 and 1980, the divorce rate in California nearly doubled, a trend that has leveled off since 1980 (Table 3-6). This trend occurred nationally as well (Figure 3-3). We cannot determine precisely what percentage of children currently in California will experience parental divorce, because divorce rates change constantly. Again, researchers have been able to make reasonable estimates, based on analyses of trend data. They estimate that at least 35 to 40 percent of all children born in the United States since 1972 will experience parental divorce before reaching age 16, assuming no major increases or decreases in the divorce rate.[15]

These figures probably will vary somewhat for California's children. Divorce rates differ by region, by religious group, by race and ethnicity, and by parent education and income level. Divorce is most common among black families and least prevalent among Asian families. The percentage of children experiencing divorce may be smaller in California, because California has a smaller percentage of black families than the national average, and a

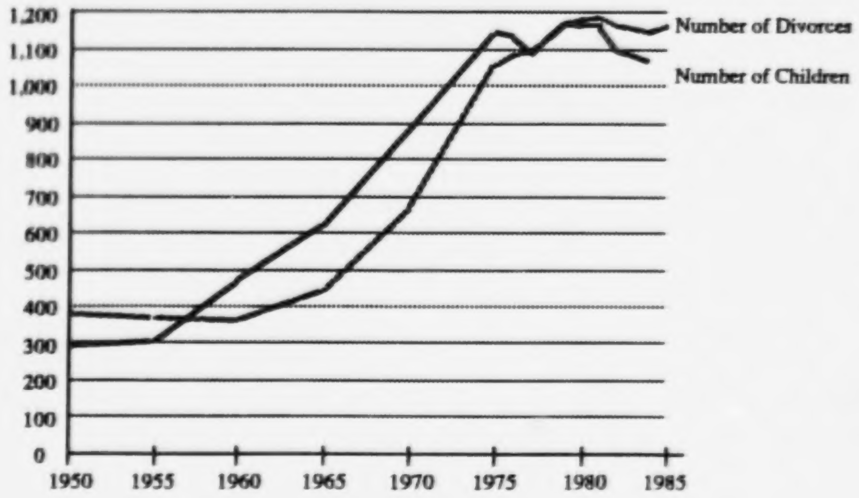
TABLE 3-6 Divorce Rates in California, 1965 to 1985

	1965	1970[a]	1975	1980	1985
California					
Total Decrees	69,926	112,942	128,987	138,914	140,845
Rates (per 1,000 population)	3.8	5.6	6	5.8	4.8
United States					
Rates (per 1,000 population)	n.a.	3.5	4.8	5.2	4.8

[a] Effective January 1, 1970, the Family Law Act replaced the term "divorce" with "dissolution of marriage" and the term "annulment" with "judgment of nullity."

SOURCE: *Vital Statistics of California*, 1965, 1970, 1975, 1980, and 1985.

FIGURE 3-3 Number of Divorces and Children Involved in Divorces in the Nation 1950–1985



SOURCE: U.S. Department of Education, *Youth Indicators, 1988*

higher percentage of Asian families.[18] In addition, divorce is more prevalent in families that have lower incomes and where the parents have completed fewer years of schooling. Californians tend to be better off in these regards than the nation as a whole. Still, it seems likely that at least 30 percent of the children presently living in California will experience parental divorce before they reach age 16.

Births to Unmarried Mothers. Contrary to popular belief, there has not been a substantial increase over the last twenty-five years in the overall *birthrate* (number of births per thousand women between ages 15 and 44) for single women. In fact, as Table 3-7 and Figure 3-4 show, the birthrate to unmarried black women aged 15–24 for the nation as a whole has *declined* substantially since 1960. In contrast, the birthrate of unmarried white women increased significantly, although the rate for white women remains considerably below that of black women. We lack trend data for Asians and Hispanics. Because there are many more white women in the general population, and the total number of women in the population has increased in recent years, the *number* of children born to single mothers has increased.

TABLE 3-7 Births to Unmarried Women, United States (in thousands)

	1960	1970	1975	1980[a]	1985[a]
Total births to unmarried women	224	399	448	666	828
Nonmarital birthrate[b]					
Total	21.6	26.4	24.5	29.4	32.8
White	9.2	13.9	12.4	17.6	21.8
Nonwhite	98.3	89.9	79.0	77.2	73.2
Black	n.a.	95.5	84.2	82.9	78.8
Hispanic	n.a.	n.a.	n.a.	52.0	n.a.
Nonhispanic	n.a.	n.a.	n.a.	27.7	n.a.

[a] Since 1980, these numbers have been produced by a new method. This change has increased estimates of childbearing to unmarried women, particularly among older women. Since younger women account for the majority of all births to unmarried women, the overall effect of the new method has been small, increasing the estimated number of births to unmarried women in 1980 by 3.5 percent. (National Center for Health Statistics, "Advance Report of Final Natality Statistics," in *Monthly Vital Statistics Report* 31:8. Supplement, 1980.)

[b] Births per 1,000 unmarried women ages 15–44.

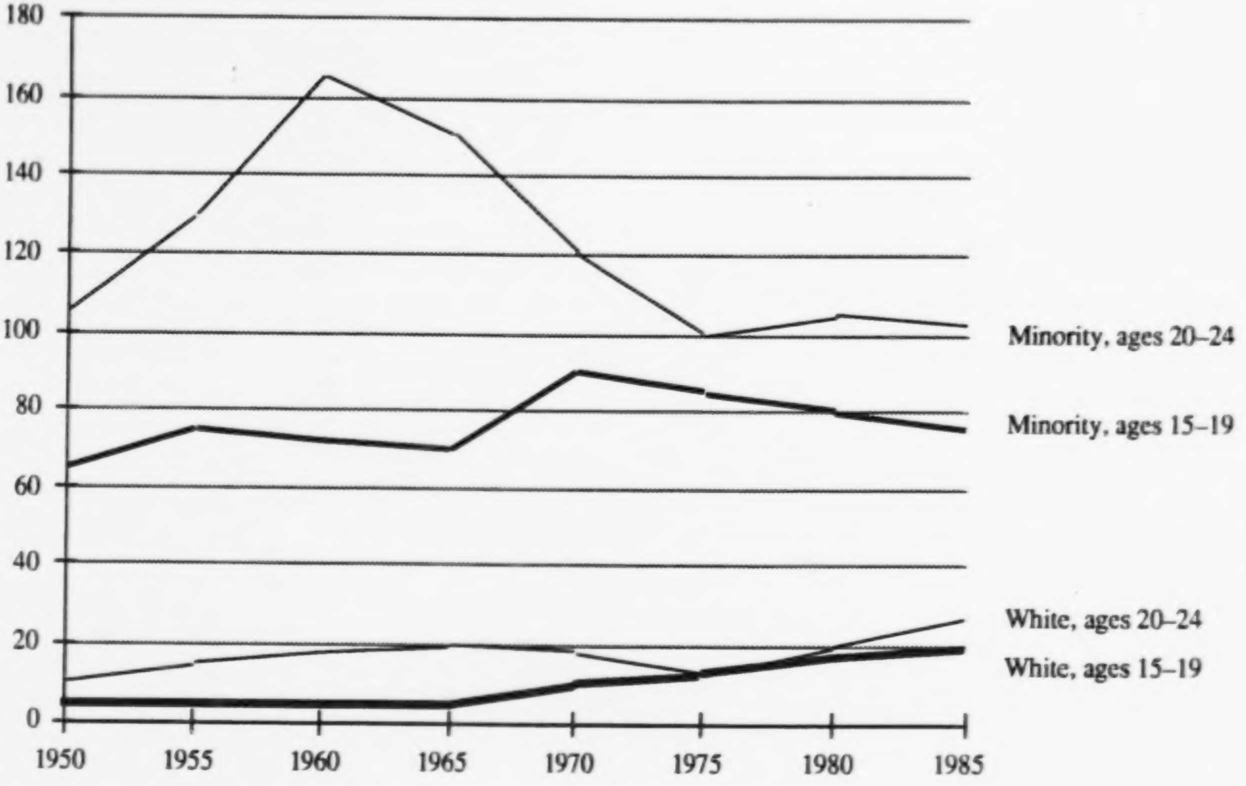
SOURCE: Andrew Cherlin, *The Changing American Family and Public Policy*, 1988.

The *ratio* of children born to single mothers to children born to married couples has also increased dramatically over the last twenty-five years, and the trend continues. The national trends hold for California. In 1986 in California, one baby in four (26.4 percent) was born to a single mother. The comparable figures were one in ten in 1966, and one in five in 1975 (Table 3-8). These figures vary substantially among racial and ethnic groups, as shown in Table 3-8. In 1986, 25.5 percent of white children were born to single mothers, and 52.3 percent of black children were so born. The figure for Hispanics was 35.3 percent. The overall increase in the ratio of non-marital births to marital births partly reflects the increased rate of births among nonmarried white women; however, the primary reason is that over this period the number of children born to married couples declined steadily. Contrary to popular perceptions, most unmarried mothers are over age 20. The proportion of nonmarital births to teenage mothers has declined substantially in the past twenty years (Table 3-9).

Summary

Overall, family structure has changed significantly over the last thirty years. Today, as a result of divorce, separation, and births to unmarried mothers, approximately one in ten Asian and two in ten white children live with a single parent. Nearly three in ten Hispanic children live with a single parent, a percentage that has been growing especially rapidly in the past eight years. Among black children, more than half live in a single-parent home. Looking at both divorces and births to unmarried mothers, based on national data, it is likely that between 25 and 35 percent of white children will live with a single parent at some point; between 35 and 40 percent of Hispanics will also do so; and nearly 90 percent of blacks will do so. There are not enough data to make estimates for children of Asian families.

FIGURE 3-4 Births to Unmarried Women in the Nation, by Age and Minority Status, 1950–1985



SOURCE: U.S. Department of Education, *Youth Indicators, 1988*.

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TABLE 3-8 Ratio of Nonmarital to Marital Births in California, 1966 to 1986

	1966	1970	1975	1980	1985	1986
Ratio of nonmarital births to marital births	0.10	0.14	0.20	0.26	0.25	0.36
Nonmarital births as percent of total births of same race/ethnicity						
White	7.6%	9.8%	13.7%	28.7%	22.6%	25.5%
Black	28.9	42.3	46.9	49.6	58.2	52.3
Asian	n.a.	2.6	n.a.	n.a.	n.a.	n.a.
Native American	n.a.	24.9	n.a.	n.a.	n.a.	n.a.
Hispanic	n.a.	n.a.	n.a.	n.a.	32.3	35.3
Other	n.a.	6.4	n.a.	n.a.	n.a.	n.a.

SOURCE: *Vital Statistics of California*, 1966, 1970, 1975, 1980, 1985, and 1986.

TABLE 3-9 Nonmarital Births in California, by Age and Race/Ethnicity of Mother, 1966–1986

	1966	1970	1975	1980	1985	1986
Total	31,804	45,593	52,854	83,373	115,444	127,457
Percent of total nonmarital births in which mother's age was less than 20	41.8	42.8	42.1	33.2	26.4	25.5
White	22,204	31,052	36,556	59,464	86,374	96,409
Percent of all nonmarital white births in which mother's age was less than 20	39.4	40.7	41.2	33.4	26.1	25.2
Black	9,124	13,602	15,018	19,500	23,435	25,149
Percent of all nonmarital black births in which mother's age was less than 20	48.2	48.0	45.2	34.0	27.9	27.2
Hispanic					48,145	55,277
Percent of all nonmarital Hispanic births in which mother's age was less than 20					26.5	25.3

SOURCE: *Vital Statistics of California*, 1966, 1970, 1975, 1980, 1985, and 1986.

Teenage Motherhood[17]

The number of children born to teenage mothers is a statistic of particular importance to people concerned about the condition of children. Many teenage mothers are, at least chronologically, children themselves. When they have children, many young women jeopardize their own future; they complete less schooling, are less likely to find employment, and are more likely to spend a substantial period of time living in poverty than are teenagers of similar backgrounds who do not have children. Their children also are at greater risk of experiencing developmental problems.

When people express concern over teenage motherhood, it is not clear, however, whether they are concerned about births to all teenagers, including 18- and 19-years-olds, and with births to married, as well as unmarried, mothers. In 1986, nearly 53,000 children were born in California to mothers under age 20; of these, approximately 19,000 (36 percent) were to mothers under age 18. Overall, teenage mothers accounted for one in nine births.[18]

Again contrary to popular perceptions, the overall *birthrate* to teenage mothers has declined considerably over the last twenty years. In 1970, the birthrate for California teenage mothers was approximately 69 per thousand. It was approximately 53 per thousand in 1985 (Table 3-10). This rate has remained essentially unchanged since 1973, and differs little from the U.S. rates. There has, however, been an increase in the rate of births to very young mothers, those age 15 or under. The rate is still quite low (1 per thousand) as is the actual number of births—901 in 1986. Fathers of babies born to teenage mothers are typically several years older than the mothers. More than a fourth (28 percent) of these fathers are teenagers themselves. About half are between ages 20 and 24 and an additional twenty percent are over the age of 24.

Of the 52,718 births to teenagers in 1986, 78.5 percent were first births (that is, the mother had not previously given birth to any live children). Over 20 percent were second or third births.[19]

TABLE 3-10 Age-Specific Live Birthrates, California and the Nation, 1970 to 1986

	Age of Mother	
	Under 15	15–19
California		
1986	1.1	53.2
1985	1.0	52.5
1984	1.1	51.1
1983	1.0	51.4
1982	1.0	52.8
1981	1.0	53.7
1980	0.9	52.5
1979	0.9	52.2
1978	0.9	51.2
1977	0.9	51.3
1976	0.9	51.0
1975	0.9	51.0
1974	0.8	51.4
1973	0.8	51.4
1972	0.8	54.5
1971	0.8	58.0
1970	0.8	68.9
1965	0.6	74.3
1960	0.6	102.2
1950	0.6	92.0
United States		
1985	1.2	51.3
1984	1.2	50.9
1983	1.1	51.7
1982	1.1	52.9
1981	1.1	52.7
1980	1.1	53.0
1979	1.2	52.3
1978	1.2	51.5
1977	1.2	52.8
1976	1.2	52.8
1975	1.3	55.6
1974	1.2	57.5
1973	1.2	59.3
1972	1.2	61.7
1971	1.1	64.5
1970	1.2	68.3

Note: An age-specific live birthrate is the number of live births per thousand women in a specifc age group.

SOURCE: *Vital Statistics of California*, 1970, 1986.

There is substantial local variation within the state. For example, in 1986 the birthrate for teenagers aged 15–19 ranged from a low of 8.8 per thousand teenage females in Marin County to a high of 91.7 per thousand in Tulare County (Appendix Table 3-1). (Sierra County had no such births.) These local variations, in part, reflect the different racial and ethnic composition of the populations, because there are substantial differences in birthrates to teenagers of different race or ethnic groups, with blacks and Hispanics having higher rates than whites. Births to teenagers account for a larger percentage of all births to blacks and Hispanics than to Asians and whites.

The overall decline in the birthrate of teenage mothers is due both to an increase in the availability of contraception and in the use of abortions. The percentage of teenage girls who are sexually active has increased steadily over the past twenty years. California has the second highest adolescent pregnancy rate in the nation, but ranks twenty-sixth in adolescent births. Approximately 45 percent of all pregnancies among 15- to 19-year-olds end in abortion.

Although fewer teenagers are having children, a much smaller percentage of teenage mothers are married than in the past. In 1986, only 32 percent of new teenage mothers in California were married, as opposed to 62 percent in 1970. The younger the mother, the less likely she is to be married. For mothers under 18 years of age, 73 percent were unmarried at the time of birth in 1986; in comparison, 55 percent of 18- and 19-year-olds giving birth were unmarried. As can be seen in Table 3-11, there are substantial variations in the marital status of teenage mothers among different ethnic groups.

TABLE 3-11 Age-Specific Live Births to Teenage Mothers, Number and Percent, by Marital Status and Ethnicity, California, 1986

	White		Hispanic		Black		Asian		Other		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Age 10–14	189	100.0%	403	100.0%	229	100.0%	43	100.0%	37	100.0%	901	100.0%
Married	22	11.6	67	16.6	13	5.7	26	60.5	3	8.1	131	14.5
Not Married	167	88.4	336	83.4	216	94.3	17	39.5	34	91.9	770	85.5
Age 15–17	5,738	100.0	8,502	100.0	3,127	100.0	414	100.0	573	100.0	18,354	100.0
Married	1,702	29.7	2,618	30.8	293	9.4	265	64.0	156	27.2	5,034	27.4
Not Married	4,036	70.3	5,884	69.2	2,834	90.6	149	36.0	417	72.8	13,320	72.6
Age 18–19	12,594	100.0	14,522	100.0	4,537	100.0	719	100.0	1,091	100.0	33,463	100.0
Married	6,559	52.1	6,733	46.4	741	16.3	520	72.3	515	47.2	15,068	45.0
Not Married	6,035	47.9	7,789	53.6	3,796	83.7	199	27.7	576	52.8	18,395	55.0

SOURCE: California Department of Health Services, Health Data and Statistics Branch.

Family Structure and the Condition of Children

We emphasize the preceding statistics because there is good reason to believe that the increase in divorce and single parenthood, with their attendant changes in family structure, have had a significant impact on the conditions of children. As previously indicated, one must be very cautious when considering these data. Some children do well and some poorly in homes with two biological parents, in stepfamilies, and in single-parent homes. Although divorce is often traumatic for children, it is not necessarily more traumatic than living in a two-parent family marked by conflict. Many children from divorced families benefit when their custodial parent remarries. Family income increases, and the child may form a close relationship with the new parent.

Still, substantial evidence shows that the condition of children is related to family structure. Perhaps most significantly, the income of single mothers, especially mothers who have never married, is significantly lower than that of two-parent homes. Nearly half (43.5 percent) of all single-mother families live in poverty. In later chapters, we report that growing up in poverty is associated with poorer health, poorer academic performance, increased delinquent behavior, and less general satisfaction.

Family structure also is related to a number of other factors that may influence a child's well-being. Single-parent families differ from two-parent families in terms of parental education, parental employment status, parental age, and—not surprisingly in light of the income data—dependence on public assistance. Each of these differences may affect the well-being of children.

Problems associated with low income are common to all groups of single parents, regardless of whether the mother is single due to divorce, separation, or never marrying. In addition, some effects may be related to whether the mother's low-income status resulted from divorce, separation, or unmarried parenthood. Therefore, we look at each group separately.

Divorce

Because family structure is so closely related to family income, it is extremely difficult to determine whether there are aspects of family structure *independent of income* that account for the difference in children's well-being associated with differences in family structure. However, from recent research studies that have followed the development of children for several years after divorce, it appears that, in addition to the economic impact of divorce on both parents and children, divorce is related to children's well-being in at least the following three ways.[20]

First, a large body of research finds that divorce is a painful process for virtually all children, as it is for most adults. At least for a period of time following the divorce, many children experience extreme anxiety, behave poorly in school, and blame themselves for the divorce. Most children ultimately cope with these feelings and adjust to a new family structure, but a small percentage of children may experience serious long-term emotional problems. For example, one national study of children between 7 and 11 years of age found that 13 percent of children from divorced families versus 6 percent of children from two-parent, nondivorce families had received treatment for mental health problems.[21] Again, it must be recalled that these comparisons are only relative; most children do not experience serious problems. Still, the incidence of problems is increased.

Second, divorce affects children through its impact on the parenting skills of the custodial parent. (Despite legal changes encouraging the use of joint custody, most divorces result in mothers assuming primary physical custody.) In many families, the stress of the divorce, the decline in income, and the need to assume roles and tasks performed previously by the other spouse, all combine to diminish the time and energy that a single parent can give to children and lessen the monitoring of children's behavior by the parent.[22] These changes in parental behavior may be the reason that parental divorce seems to increase the likelihood that a child will do more poorly academically than he or she might otherwise have done. Also, some studies find that children who have experienced divorce are more likely to use drugs or alcohol at an earlier age, to begin dating earlier, to engage in sexual activity at an earlier age, to become pregnant more often, and to marry as teenagers.[23]

Finally, divorce is sometimes associated with substantial ongoing conflict between the former spouses. Often , children are caught in the middle of these conflicts. These children are especially likely to experience emotional and academic problems.[24]

Again, it must be stressed that these are only probabilities: many children living with both their parents have academic, social, and emotional problems; many children from divorced households do not. Moreover, if the economic situation of divorced single mothers were not so precarious, there might be less decline in parenting skills. Still, it seems likely that single parenthood, in and of itself, affects parenting skills.

Remarriage by a custodial parent, which virtually always improves the child's economic situation, does not, in general, seem to reduce the negative consequences that some children experience following divorce. The scant available research finds that, in general, remarriage does not help the child improve academic performance or reduce emotional problems.[25]

The impact of divorce on a child, and the condition of the child in the postdivorce family, appears to be influenced by a number of factors:

- The sex of the child (at least among younger children, boys show more problems, especially with respect to acting-out behavior and academic problems)
- The quality of the parent-child and parent-parent relationships in the predivorce situation
- The economic circumstances of the postdivorce family, and the amount of conflict during and after the divorce
- The postdivorce adjustment of each parent, especially the parent who has primary custody
- The relationship, if any, with the noncustodial parent
- The age of the child
- The availability of support from extended family and other social support systems.

A number of policies are now being implemented in an effort to mitigate some of the more damaging aspects of divorce. These policies include better enforcement of child support, so that custodial parents do not experience a substantial drop in income, and mediation programs designed to minimize postdivorce conflict. Since there is little likelihood of a significant decline in divorce rates, the availability—or lack thereof—of support systems for custodial parents will greatly affect the condition of children in California.

Unmarried Parents

Most studies examining the condition of children in single-mother families do not distinguish between families where there has been a divorce or separation and families where the mother is unmarried at the time of the child's birth. Thus, it is difficult to draw firm conclusions about the relationship between unmarried motherhood and the condition of children. Moreover, many women who are unmarried at the time a child is born eventually marry (and perhaps divorce). There also may be periods during which they live with a man. Some never-married mothers live with other adults, including relatives. We do not have data distinguishing the condition of children in each of these settings.[26]

We do know, however, that never-married mothers are, on average, even poorer than divorced mothers. They tend to be younger, to have completed less education, to be more dependent on the welfare system, and to be more likely to live in poor housing. Because of these factors, it is likely that, as a group, their children are in worse condition than children of divorced parents.

Children of Teenage Mothers

It is generally assumed that children living with teenage mothers are an extremely "high-risk" group and that we can expect their condition to be considerably worse than that of other children. In light of the popular image, it is surprising that extremely little research examines the well-being of children born to teenage mothers.[27] What little research there is has focused almost exclusively on very young children; only one study has followed children into adulthood. Most studies do not separate out married teenagers from unmarried teenagers or older from younger ones. Those studies that do look only at unmarried teenage mothers generally contrast their study children with *all* other children, rather than with those of *unmarried older* mothers. Thus, it is difficult to know whether any problems the children evidence are related to their mothers' age, rather than to marital status. In addition, the vast majority of studies look only at black mothers, even though they do not constitute the majority of teenage mothers (in California or in the nation). We do not know whether findings from these studies would apply in Asian, Hispanic, or white families.

With these caveats in mind, we believe it is reasonable to expect that the condition of children of *unmarried* teenage mothers will, on average, be poorer than that of children of older childbearers.[28] The majority of young mothers are very poor, thus all the discussion in the preceding sections is relevant when discussing teenage mothers. In addition, younger adolescent mothers (under age 18) are less likely than later childbearers to complete high school, attend college, find stable employment, or become self-supporting. They also are less likely to marry eventually than are older single mothers. All these factors pose additional risks to their children's development (as well as to their own). Also, a number of studies have found that children born to teenage mothers are on average, less healthy, more likely to experience academic difficulties, and more likely to engage in harmful social behavior.

Teenage mothers, especially those who are unmarried, are more likely to have low-birth-weight children. The younger the mother, the greater the likelihood of her giving birth to a low-birth-weight child. For example, in California in 1986, the percentage of low-birth-weight babies born to girls under the age of 15 was 9.9; to mothers aged 15 to 17, it was 8.2; and to those aged 18 to 19 it was 6.9. These statistics contrast sharply to the rate experienced by women between the ages of 20 and 34—5.8 percent.[29] The differences seem to be caused by the lower amount of prenatal care received by pregnant teenagers. Teenagers who do not receive prenatal care have more than twice the percentage of low-birthweight babies as do teenagers who receive some care.[30]

Since low birth weight is the leading reason for infant mortality, it is not surprising that infant mortality rates are higher for children born to teenage mothers. Moreover, those low-birth-weight infants who survive face a multitude of risks: low-birth-weight babies *who grow up in poor families* evidence more frequent childhood illnesses, experience more hospitalizations (especially during the first year), and have poorer cognitive development (leading to poorer performance in school) than do normal-weight babies from the same socioeconomic backgrounds.[31]

It does not appear that teenage mothers provide less physical care or are less warm and loving toward their children. And when birth weight is taken into account, infants of teenage mothers are as healthy as other infants at age 1. Still, teenage mothers do exhibit some behaviors which may jeopardize their children's development. There is some evidence that infants of teenagers have more accidents, which may reflect parental inattention. Teenage mothers tend to vocalize less to their infants and to provide less cognitive stimulation. They also have less realistic expectations about what their children are capable of doing; they tend to underestimate children's capacities in cognition and language, in comparison with older mothers of similar backgrounds.

Perhaps as a result of these differences, children of teenage mothers— at least those groups of mothers who have been involved in research studies—generally show small decrements in cognitive and social functioning during elementary school compared to same-age children of older childbearers.

The negative effects on the children of teenage mothers continue into adolescence and even become more pronounced, despite the fact that the mothers are now in their twenties and thirties. In 1960, one study examined test scores of over 375,000 teenagers. Children of mothers who were teens at their birth had lower cognitive scores, lower educational aspirations, and were more likely to have become teen parents themselves.[32] These findings have been replicated in several more recent studies. Finally, the most extensive longitudinal study of children of teenage mothers, which followed nearly 300 black children in Baltimore, Maryland, from birth through age 17, found that children of teenage mothers were more likely to be retained a year or more in school, to be suspended, to drop out of school, to run away from home, to engage in delinquent behavior, to engage in early sexual activity, to become pregnant, and to have a child as a teenager, than were black children born to older mothers.[33]

In sum, we can expect that the condition of children born to teenage mothers—especially younger, unmarried mothers—will, on average, be somewhat worse than that of children born to older mothers. Even if maternal age itself does not account for the differences—and it does seem to have some independent effect—the fact that teenage mothers overwhelmingly are very poor, have completed less schooling, and often lack social support systems, means that, as a group, they will have more trouble providing adequate care for their children. Special support systems, for both the mothers and children, clearly are necessary if their children are to be afforded adequate, let alone equal, opportunity.

As we stressed in discussing divorce and single parenthood, while teenage motherhood increases the likelihood that a child will experience difficulties, many children of teenage mothers fare quite adequately. Moreover, existing studies tell us very little about the children of Asian, Hispanic, white, or married teenage mothers. There are substantial cultural differences among various ethnic groups with regard to age of marriage, role of women, and role of extended family in the care of children. Still, knowing the percentage of children in the state's population born to teenage mothers does provide an important indicator of the present and future condition of California's children.

Parental Employment

Changes in family structure have been matched by changes in how family members, especially mothers, spend their time. Less than a third of California's children live in the traditional household with a working father and homemaker mother (Table 3-12). Forty-five percent live in households in which either both parents or the only parent is working. This pattern holds for the nation as a whole, and does not appear to have changed greatly during the past five years, although it constitutes a change from twenty or thirty years ago. As a result, children spend considerably more time in the care of people other than their parents.

Conclusion

Although evidence is limited, we believe that the changes in family structure over the past thirty years have had a negative impact on the well-being of many children. There is no evidence that as a result of these changes most parents are any less committed to their children than in the past. However, the economic and emotional toll of divorce and single parenthood on parents, and the loss of the extra monitoring and support that can be provided by two parents, does affect the academic, social, and emotional development of some children.

It seems unlikely that divorce will substantially decline in the near future. A number of approaches are being used to try to reduce teenage pregnancy. If successful, they may also reduce the number of births to older unmarried women.

However, to improve the well-being of children, it will also be necessary to alleviate the economic stress that accompanies single parenthood. We examine the impact of poverty in the next chapter.

TABLE 3-12 Employment Status of Parents, in California and the Nation, 1980–81 to 1985–86

	1980–81		1985–86	
	California	United States	California	United States
Total parents in thousands	9,185	107,927	8,399	89,292)
Both parents in household				
Both working	33.8	34.0	32.5	35.0
Father working, mother not working	32.3	33.9	28.9	28.5
Mother working, father not working	3.2	3.3	3.9	3.8
Neither working	2.5	2.2	2.9	2.4
Neither in labor force	3.5	2.8	6.1	4.0
One parent in household				
Parent working	12.8	11.2	12.4	12.4
Parent unemployed or not in labor force	8.3	8.6	10.4	11.0
Neither parent in household	3.6	4.0	2.9	3.0
TOTAL	100.0	100.0	100.0	100.1

Note: "Not working" means unemployed. "Not in labor force" means unemployed and not looking for employment.

SOURCE: Child Trends, Inc. from Current Population Surveys.

Chapter 4

Economic Status

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As emphasized throughout this report, a child's well-being depends on many factors. Undoubtedly, the most important factor is the quality of parental care. After that, the most consistent *predictor* of a child's *lack of well-being* is the family's economic status. Children from wealthy families are not necessarily better off, in terms of health, academic achievement, or emotional well-being, than children from moderate-income families. However, living in a household with minimal income often means that a child is deprived of basic necessities or of adequate opportunities for full development. Limited income also can affect the quality of parental care.

The well-being of children is affected by both the *absolute* level of their families' income and by their *relative* economic status. At a minimum, children need access to adequate food, clothing, shelter, and medical care to prevent illness and to allow them to function in school. Although the concept of adequacy depends, in part, on the general standard of living in a community, state, or country, minimum levels of nutrition, shelter, and medical care are necessary for health, safety, and basic development. Unfortunately, some parents cannot provide even basic necessities. Even if a family is able to provide "basic necessities," families with limited income may not be able to meet many of the needs of children. As we show in this chapter, poor children—that is, children whose families live below, at, or just above, the poverty line—seem, in addition to having fewer material goods, to be in worse condition physically, academically, and emotionally than other children.

Moreover, in a wealthy society such as the United States, a child's *relative* economic status is an important indicator of that child's future development. Many studies have found that the economic status of a child's family is the single most powerful predictor of a child's opportunity for success and self-sufficiency in adulthood.[1] A family's economic status often determines the quality of the neighborhood in which the child lives; the child's access to services such as libraries, parks, and youth organizations; the availability of complete medical care; and many other important resrouces. In addition, relative deprivation can negatively affect aspirations and self-concept.[2]

We examine the economic status of all California households with children. Our main focus, however, is on children living in poverty, because of poverty's profound effect on children's well-being. We first identify the children living in poverty, in order to better understand why they are poor. We then discuss the impact of living in poverty on the condition of children. We conclude by describing public programs that provide income support for families with children.[3]

An Overview

The economic status of children generally depends on four factors: the family income, the number of children in the family, the portion of the family income the parents choose to spend on goods and services that directly or indirectly benefit the children, and the amount society chooses to invest in children beyond that which their parents can and will invest in them. In addition, many older children work, which increases their economic well-being (assuming parents do not reduce their investment on a dollar-for-dollar basis) and, perhaps more importantly to teenagers, increases their discretionary income.

Looking at the situation over the last thirty years, the picture is clear. Between 1959 and 1969, the economic well-being of most children increased considerably.[4] Four factors contributed to a significant increase in the average income available to children and a large decrease in the number of children living below the poverty line: (1) increasing family income, (2) decreasing family size (which meant that more income was available to each child), (3) federal efforts to combat poverty, and (4) increased government spending on education and other social programs.

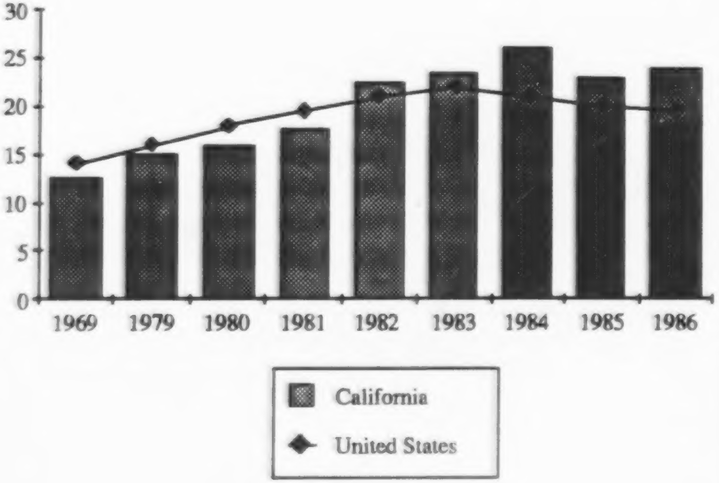
Since 1969, however, and especially since 1979, the economic well-being of many children in California and the nation has deteriorated (although the situation for children in the wealthiest 20 to 30 percent of families has improved). Perhaps most important, the number of children living in poverty in California almost doubled between 1969 and 1987. *Today more than one in five children in California live in families whose income is below the federally defined poverty level.* Many more children live just above the poverty line.

Poverty is defined in terms of monetary income. Many poor families and children also receive nonmonetary income, in the form of food stamps, free medical care, housing assistance, and school lunches. There is substantial controversy over how such benefits should be valued. Regardless of how one values these other benefits, it must be recognized that families classified as poor have considerably less total resources available to them than most other families. Moreover, research shows that children living in families below the poverty line, *however defined*, tend to be in worse condition than other children.

The trend toward more children living in poverty is a national one. Moreover, in recent years, California has changed from being a state in which children fared relatively well, compared with children nationwide, to one in which children fared relatively worse. Between 1969 and 1981, California's proportion of children living in poverty was smaller than the nation's as a whole. Since 1981, California's percentage has been higher than the national percentage (Figure 4-1). However, the percentage of poor children in California is lower than in most other large states (Figure 4-2).

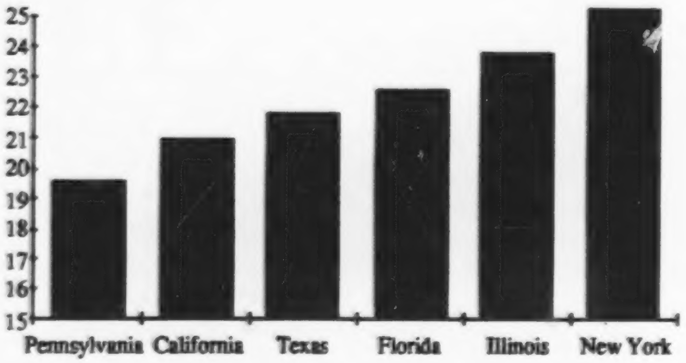
Not only are more children living in poverty, but the income disparity between children living in the poorest families and children living in all other families also has grown in the past ten years. In 1986, the median income of the 20 percent of families with the lowest income (bottom quintile) was $8,919 (which means that half of the families in this group were below this amount). The median income for the 20 percent of families with the highest income was $69,662, nearly eight times as great. In 1977, the comparable figures (in 1986 dollars) were $9,796 and $61,176, a sixfold difference; thus, the income disparity between the highest group and lowest group has widened substantially since 1977. Because lower-income families tend to have more children than higher-income families, the disparity in funds available for each child in these families is even greater.

FIGURE 4-1 Proportion of Children Below the Poverty Line, California and the United States, 1969–1986



SOURCE: Current Population Survey Profile, California State Census Data Center, 1986.

FIGURE 4-2 Percent of Children in Poverty in Six Large States, 1985–86



SOURCE: Child Trends, Inc. compiled from Current Population Surveys, 1985 and 1986.

As a group, children are worse off than adults. In every year since 1969, there has been a greater percentage of children than adults living in poverty. In part, this is due to the fact that more children live with single mothers than was the case twenty years ago, and single mothers tend to have low incomes. But the situation of many children living with two parents has also deteriorated substantially. In fact, economist Victor Fuchs has shown that poverty rates for children would have increased between 1969 and 1984 even if there had been no increase in the proportion of families headed by single parents. (It is interesting that the opposite situation has occurred with respect to the elderly, who have experienced a substantial reduction in poverty, largely because income transfer programs to the elderly have been much more generous than income programs for children.)

In the rest of this chapter, we elaborate on the preceding points. We begin by looking at the general picture for all children.

Income of Households with Children

Table 4-1 presents the median income of all families with children, by family type, in 1969 and 1979, the last year for which we had such data. The dollar amounts are adjusted for inflation. As can be seen, for those married couples in which both parents were in the labor force, median income increased slightly over this period. In contrast, couples with only one wage earner experienced a 5 percent decrease in income. During this period, the proportion of married women in the labor force increased substantially. Although this meant that the children in these families benefited from increased dollar income, their total economic well-being may not have increased, because they lost the goods and services previously provided by the parent who was not in the labor force.

Substantial differences in income are related to family structure. Two-parent families have considerably more income than single-parent families. Families headed by women have especially low incomes; the *median* income for these families is barely above the poverty line for a family of four. Single parents frequently bear substantial child care expenses, further reducing the economic well-being of their children.

Income Distribution

Median income figures give us a sense of the economic status of children in general. However, the income available to individual children varies substantially. Table 4-2 shows the distribution of income among families with children. The families are divided into quintiles; each quintile represents 20 percent of all families with children. The dollar figure shows the median income for that quintile—half of all families had incomes below that figure, half above.

TABLE 4-1 Median Family Income in California, by Family Type, 1969 and 1979

	Median Family Income		
	1969[a]	1979	Percent change 1969–79
All families	21,439	21,537	0.5
Married couple	22,985	23,869	3.8
Wife in labor force, with children	26,680	27,213	2.0
Wife not in labor force, with children	22,372	21,253	-5.0
Male householder			
No spouse	19,101	17,989	5.8
No spouse, with children	n.a.	16,393	n.a.
Female householder			
No spouse	10,708	11,088	3.6
No spouse, in labor force, with children[b]	n.a.	11,317	n.a.
No spouse, not in labor force, with children[b]	n.a.	4,982	n.a.

[a] 1979 dollars.

[b] Data for female householders with children overall are not available for 1969. These median incomes are women alone, other than widows, who are few and of higher median income.

Notes: Published CPI deflators for 1969, 1979 used. (1967 base: 1969—1.098, 1979—2.174).

SOURCE: U.S. Bureau of the Census, 1980.

Table 4-2 shows that there is substantial disparity between the highest and lowest groups. Since wealthy families tend to have fewer children, the disparity among children is even greater that that shown in the table. Moreover, as the trend data show, between 1977 and 1986 the income of the worst-off 20 percent of families declined (when income is adjusted for inflation), the income of the next 40 percent of families remained basically the same, while the income of the wealthiest 40 percent increased. The wealthier the family, the more its income increased. Thus children in wealthier families have become both absolutely and relatively better off.

Children in Poverty

In 1987, 1.78 million California children, over 23 percent of all children in the state, lived in poverty. This percentage constitutes an increase of nearly eleven percentage points since 1969; expressed differently, there has been an 83 percent increase in the proportion of children in poverty over the past twenty years. Much of this increase has occurred since 1980 (Table 4-3).

The percentage of children in poverty at any one point tells only part of the story. A considerably higher percentage of children will live in poverty for some period of time during their childhood. For most of these children, the period of time in which they will live in poverty will be relatively brief– from just a few months to several years. Some children, however, will spend all or most of their childhoods living below the poverty line.[7]

Who are the Poor Families?[8]

Children are poor because their families have limited income. For most families, the major source of income is payment for work. The likelihood that a family will have limited income is related to a number of factors, the most important of which are family structure, parents' education, and parents' age. In addition, the likelihood of being in poverty is affected by family size. Finally, there is an association between poverty and ethnicity independent of these other factors. Table 4-4 shows the prevalence of poverty in families with differing characteristics. It also contrasts the characteristics of poor families with families that have income that is less than twice the poverty level and all other families.

TABLE 4-2 Income of All California Families with Children, 1977-86, by Quintiles (constant 1985 dollars)

	Median Income of Quintile				
	I (1-20%)	II (21-40%)	III (41-60%)	IV (61-80%)	V (81-100%)
1977	$9,796	$18,988	$28,879	$39,783	$61,167
1978	9,915	19,137	30,113	41,697	62,964
1979	9,800	19,827	30,113	43,129	67,110
1980	9,639	19,413	29,703	43,734	69,675
1981	9,396	19,148	29,050	41,233	63,254
1982	8,406	17,678	27,663	39,934	65,401
1983	8,211	17,354	27,116	39,857	67,223
1984	8,274	17,672	27,493	40,131	66,813
1985	9,098	19,280	29,029	41,943	68,488
1986	8,919	19,682	29,892	43,673	69,662
Net Change	9.0%	3.7%	3.5%	10.0%	14.0%

SOURCE: California Senate Office of Research. Current Population Surveys, California State Census Data Center.

TABLE 4-3 Poverty Among Children in California and the United States, 1959–1987 (in thousands)

	1959	1969	1975	1979	1980	1981	1982	1983	1984	1985	1986	1987
Percent of children in California in poverty	—	12.7%	18.6%	15.2%	17.9%	22.5%	23.4%	25.6%	22.8%	24.3%	22.6%	23.6%
Number of children in California in poverty	—	828	1,142	946	1,145	1,472	1,538	1,731	1,583	1,723	1,647	1,785
Percent of children in the U.S. in poverty	26.9%	14.9	16.8	16.0	17.9	19.5	21.3	21.8	21.0	20.1	19.8	—

Note: These are rates among "related children." Rates would be very slightly higher (by a few tenths of a percent) were all children included.

SOURCE: Statistical Abstracts, 1982, 1988. Current Population Surveys, California State Census Data Center.

TABLE 4-4 Selected Characteristics of Children in California and the Nation Living Above and Below the Poverty Line, 1985–86

	Percent of Children from Families with Incomes:					
	Below the Poverty Line		1–1.99 X the Poverty Line		2 X the Poverty Line and Above	
	California	U.S.	California	U.S.	California	U.S.
All Children	21.0%	20.7%	21.5%	22.9%	57.5%	56.4%
White (52.6)	26.0	44.5	37.0	65.9	68.1	83.6
Black (7.9)	12.0	32.3	7.9	17.7	6.4	7.6
Hispanic (29.3)	48.9	19.0	45.9	13.0	15.9	5.4
Other (Asian) (10.3)	13.1	4.2	9.3	3.3	9.6	3.2
Two parents (74.2)	51.9	40.6	71.7	71.8	83.3	86.4
Mother only (19.9)	41.3	51.3	22.4	22.2	11.1	9.2

Note: Based on the federal government's essential market basket index, in 1986 the income level for poverty was $11,203 for a family of four, $8,737 for three, and $7,138 for two. Figures in parentheses at left indicate the percentage for the total California child population.

SOURCE: Current Population Surveys.

Family Structure. Despite popular images, *the majority of poor children in California, approximately 52 percent, live in families where both parents are present* (Table 4-4). In this respect, California differs significantly from the nation as a whole, in which 60 percent of poor children live with single parents. Moreover, in most of these two-parent families one or both parents work, either full time or part time. These families are poor because the parents do not earn enough money from work to prevent poverty. Because most of these parents have limited education, their chances of finding higher-paying jobs are restricted.

During the 1980s, the high unemployment rates in California and the nation led to much greater poverty among these families, who tend to be hardest hit by periods of high unemployment. In addition, the failure of the minimum wage to keep up with inflation meant that, for a family of four or more, even if *both* parents worked full time at the minimum wage, their combined income fell below the poverty line in 1988. The situation is especially difficult for large families, since the parents must earn far more than the minimum wage to live above the poverty line.

Although the majority of poor children live in two-parent families, only a relatively small percentage of two-parent families (14.6 percent) is poor.[9] In contrast, being a child living in a single-parent household, especially a single-mother household, greatly increases the likelihood of being poor (Table 4-5). Families headed by women alone are four times more likely to be poor than are two-parent families. *Nearly half, 46.3 percent, of all such families in California are poor; in families headed by single women with children under age 6, the percentage is a staggering 58.5 percent*

TABLE 4-5 Changes in the Percent of Children in Extreme Family Income Categories from Mother-Only and Two-Parent Families in California and the Nation, 1979–80 to 1984–85

	California			United States		
	1979–80	1984–85	Change	1979–80	1984–85	Change
Mother only						
Percent < poverty level	35.7%	43.5%	7.8%	47.2%	50.1%	2.9%
Percent > 1.99 X poverty level	35.7	32.2	–3.5	26.0	24.9	–1.1
Two Parents						
Percent < poverty level	9.4	14.6	5.2	9.0	11.4	2.4
Percent > 1.99 X poverty level	70.1	64.3	–5.8	69.1	66.2	–2.9

SOURCE: Current Population Surveys.

(Table 4-6). Thus, the significant increase in families headed by single women since the 1960s, due primarily to the increase in divorce but also to the increase in births to unmarried women,[10] has resulted in many more children living in poverty.

Single mothers are disproportionately poor for three reasons. First, in most such families only one adult is available to earn income; approximately half of two-parent families have two incomes. Single-mother families have only one income because many fathers do not contribute any support; even those that do often contribute only a small amount.[11] Second, the hourly wages of single mothers are lower than the wages of other women, including those of married mothers (Table 4-7). In general, their wages are not high enough to lift them out of poverty. Finally, although the majority of female heads of families work, many depend totally on public assistance. In 1987, the maximum annual *cash* benefit for a single parent with two children equaled 83.7 percent of the poverty line; a single-parent family of four received benefits equal to 77.7 percent of the poverty line.[12]

TABLE 4-6 Percent of Women Householders, without Spouse, with Children, in Poverty, 1977–86

	1977	1981	1986
Women householders with children < 18 in poverty	42.5%	41.0%	46.3%
Women householders with children < 6 in poverty	62.5	58.3	58.5

SOURCE: California Senate Office of Research. Current Population Surveys, California State Census Data Center.

TABLE 4-7 Hours Worked and Hourly Wages, 1986

Hours worked per week	Wages of Men	Wages of Women	Wages of Women with Spouse and Children	Wages of Single Women with Children
35 +	$10.00	$7.21	$7.32	$6.40
20–34	$8.57	$6.87	$7.20	$6.38
1–19	$7.27	$6.35	$7.07	$5.00

SOURCE: California Senate Office of Research. Current Population Surveys, California State Census Data Center.

Parent's Education. Not surprisingly, adults with lower education earn lower wages and are more likely to be unemployed. Only 23 percent of all children in California, but half (49.4 percent) of all poor children, live with parents who have less than a high school education. (Many of these also are single parents.)

Family Size. Larger families are much more likely to be poor. Approximately one-third of all poor children live in families that have four or more children; overall, only 17 percent of all children live in families of this size. Large families are disproportionately poor for at least two reasons. First, many parents in these families have limited education.[13] Second, these families must earn much more money than smaller families in order to stay out of poverty. In 1976, the poverty line for a family of three was $8,737. This rose to $17,986 for a family of six, and to $18,791 for a family of eight (Table 4-8).

Table 4-8 Poverty Level Incomes by Size of Family Unit, 1986

Size of Family Unit	Poverty Income (1986 dollars)
2	$ 7,138
3	8,737
4	11,203
5	13,259
6	14,986
7	17,049
8	18,791
9 or more	22,497

SOURCE: U.S. Bureau of the Census.

Parent's Age. Families with young family heads, those under age 30, and especially those under age 25, are much more likely to be poor.[14] This is true of two-parent as well as single-parent families. As a corollary, a greater percentage of children under 5 years old are poorer than children over 5, since younger children tend to be part of families headed by younger parents.

Younger families are poorer because they tend to be headed by parents who have the disadvantages just reported. In general, younger parents have less education than older parents. Of all children in young families (family head under age 30), 75 percent live with a family head who has twelve or fewer years of schooling. Only 5 percent live in families headed by a college graduate. Over the past ten years, the economic position of workers without a college degree has declined significantly. Moreover, nearly a third of all children in young families live in a family headed by a single woman.[15]

The likelihood of being in poverty increases with the number of "risk factors" present. Nationally, among families in which there are two parents under 30, at least one of whom is a high school graduate, 10.2 percent live below the poverty line. This number increases to 84.6 percent for families headed by a female high school dropout (Table 4-9).

Race and Ethnicity. A family's race or ethnic origin is strongly related to the likelihood that the family will be poor. Approximately 10 percent of all white children were poor in 1985-86. In contrast, 27 percent of Asian, 32 percent of black, and 34 percent of Hispanic children were poor (Table 4-10). Looked at somewhat differently, white children comprised over one-half of all California children in 1985-86, but only 26 percent of the children in poverty were white. In contrast, less than a third (29.3 percent) of all California children were Hispanic, but nearly half (48.9 percent) of poverty children were Hispanic. Moreover, the recent increases in poverty have been especially great for minority children— the percentage of Hispanic children living in poverty increased from 24 to 35 percent between 1981 and 1986 (Table 4-10).

The higher poverty rates reflect, for the most part, the differences in family structure, education, and parental age among different groups. In California, they also reflect the impact of immigration. Many immigrants, who tend to have less education, work in low-paying jobs, at least initially. But even after all these factors are taken into account, "minority" group families are disproportionately poor, for reasons we cannot identify.

TABLE 4-9 Percentage of Young Families Living in Poverty by Family Structure, Educational Attainment of Family Head, and Presence of Children, 1986

	Poverty Rate
Married Couple, Family Headed by College Graduate, No Children	0.3%
Married Couple, Family Headed by High School Graduate, No Children	2.6
Married Couple, Family Headed by High School Graduate, One or More Children	10.2
Married Couple, Family Headed by High School Dropout, One or More Children	27.9
Female-Headed Family, Family Headed by High School Graduate, One or More Children	64.1
Female-Headed Family, Family Headed by High School Dropout, One or More Children	84.6

SOURCE: Children's Defense Fund, *Vanishing Dreams: The Growing Plight of America's Young Families*, 1988.

TABLE 4-10 Proportionate Increase in the Percent of Children in Poverty, by Ethnic Group, California, 1980–81 to 1985–86

	Percent in Poverty		Proportionate Increase
	1980–81	1985–86	
White	8.4%	10.4%	23.8%
Hispanic	24.4	35.0	43.4
Black	26.0	32.0	23.1
Asian	20.5	26.6	29.8

SOURCE: Current Population Surveys.

Contrast Between California and the Nation

Because California's population is quite different from that of the United States as a whole, the composition of the population living in poverty in California also differs from national statistics. White children comprise the largest subgroup of children in poverty nationally, 44 percent, but only 26 percent in California. Black children comprise 12 percent of children in poverty in California, but 32 percent of poverty children nationally. Hispanic children comprise 49 percent of California's poor children, compared with 19 percent throughout the nation.

California's poverty population differs in other ways as well. In California, a large percentage of all poor families have two parents, and a greater percentage of two-parent families are poor than is the case nationally (Table 4-5). California's poor also differ from the nation's poor with respect to parent education and family size. In part, these differences reflect the ethnic differences in California's population, compared with the nation's population. For example, the majority of poor Hispanic and Asian children live with two parents, the majority of poor white children live with a divorced mother, while the majority of poor black children live with a never-married mother. Poor Hispanics tend to have somewhat larger families and lower parental education. These and other differences in California's poverty population also relate in part to the high percentage of immigrant families in California.

These differences are very important in terms of public policies. The policy options for helping a two-parent family that is poor because of low wages are quite different from those that may be useful in helping a young never-married mother. A third set of policies may be needed to help mothers who become single parents through divorce. Yet most anti-poverty policy is established by the federal government and reflects perceptions of the national problem. Because the composition of California's poor differs from national norms, national policies may not be particularly useful for helping California's poor families.

Even within California, poverty rates vary significantly among counties. In 1979 (the last year for which we have county data), poverty rates for children under age 18 ranged from a low of 8.5 percent in Mono County to a high of 27.5 percent in Mariposa County (Table 4-11). This range reflects both differences in the characteristics of the local populations and in local economies. Thus even within the state, different policies may affect counties in varying ways.

TABLE 4-11 Percent of Children Under Age 6 Living in Poverty, California Counties, 1979

County	Percent	County	Percent
Alameda	17.3	Placer	13.5
Alpine	15.0	Plumas	15.1
Amador	9.3	Riverside	17.5
Butte	19.3	Sacramento	19.6
Calaveras	20.1	San Benito	17.7
Colusa	17.1	San Bernadino	16.8
Contra Costa	12.7	San Diego	18.0
Del Norte	16.0	San Francisco	20.6
El Dorado	11.7	San Joaquin	22.1
Fresno	22.9	San Luis Obispo	14.4
Glenn	19.1	San Mateo	9.0
Humboldt	19.9	Santa Barbara	14.7
Imperial	17.8	Santa Clara	10.7
Inyo	15.2	Santa Cruz	16.7
Kern	19.5	Shasta	16.2
Kings	23.7	Sierra	14.2
Lake	25.5	Siskiyou	17.6
Lassen	10.4	Solano	15.1
Los Angeles	21.5	Sonoma	12.7
Madero	22.1	Stanislaus	19.4
Marin	10.0	Sutter	18.2
Mariposa	27.5	Tehama	18.5
Mendocino	17.4	Trinity	17.7
Merced	22.6	Tulare	26.1
Modoc	18.9	Tuolumne	20.2
Mono	8.5	Ventura	12.7
Monterey	18.1	Yolo	20.6
Napa	12.1	Yuba	24.1
Nevada	16.0		
Orange	11.2	**CALIFORNIA**	**18.0**

SOURCE: *Back to Basics: Improving the Health of California's Next Generation*, a report of the Southern California Child Health Network and the Children's Reseach Institute of California, 1987. *Health Data Summaries for California Counties, 1984*, Center for Health Statistics, California Department of Health Services.

The Impact on Children of Living in Poverty

The focus of this book is not on poverty per se, but on the condition of children. There are, however, many reasons to be concerned about the well-being of children living in or near poverty. Living in poverty is associated with many undesirable outcomes for children, from higher mortality rates to lower high school graduation rates. Thus, for example, one national study found that children living in families with incomes below the poverty line have mortality rates, in infancy and early childhood, three times higher than other children.[16] Other studies have shown that they are more likely to suffer serious illness,[17] more likely to be abused or neglected,[18] and more likely to drop out of school.[19] They are much less likely to continue education beyond high school[20] and more likely to become pregnant as teens than are those who are not poor.[21]

Although we know that living in poverty greatly increases the risk of such unfavorable outcomes for children, we know less about why this is so. Unquestionably, the lack of resources in and of itself harms children. As we show in other chapters, poor children are less likely to have access to medical care, more likely to live in substandard housing and in neighborhoods that have high crime rates, more likely to be victims of crime, and more likely to engage in delinquent activity. The schools they attend often are poorer in quality, and, at least in urban areas, poor children may have less access to recreational facilities, parks, and libraries. Moreover, the parents of these children often live under a great deal of stress. As a result, some poor parents may be less able to provide adequate care for their children on a consistent basis. Again, it should be emphasized that children living in families just above the poverty line also experience these problems; in fact, they may have even less access to medical services.

Still, there is reason to believe that it is not solely the absence of adequate income that affects the well-being of children, or the quality of parenting, *in at least some poor families*. As previously discussed, there are significant differences between poor families as a group, and the rest of the population as a group, with respect to a number of factors that may influence the condition of children. In particular, poor parents, on average, have less formal education than nonpoor parents, and they are more likely to be single and to be young. There is research indicating that family structure, parental age, and parental education all are associated with differences in the way many parents relate to their children, differences that may affect the well-being of children. We have previously described, in Chapter 3, some impacts of family structure and parental age on parenting skills.[illegible] Increasing family income may not necessarily alter these behaviors.

It must be underscored that poor families differ from each other, as well as from nonpoor families. The experiences (and condition) of a child growing up in a poor two-parent family in a rural area undoubtedly are far different from those of a child living with a young never-married mother in an urban ghetto. Both groups differ from recently divorced mothers. Some families are poor for relatively short periods of time. Others move in and out of poverty, while some families remain poor for many years and their children grow up in poverty. Never-married mothers are more likely to remain poor than are divorced mothers or couples with children.

The crucial point for policymakers is that the percentage of children in poverty tells us only a limited amount about the *condition* of children in general, and very little about the condition of any individual child. Some children—we do not know how many—living in poverty are developing quite adequately, even though they are deprived of many material things. The development of many other children living in poverty has been negatively affected just because they live in poverty; improving their families' income certainly will promote the children's well-being. Yet for some children it seems likely that programs aimed *only* at improving their parents' economic situation, however necessary and just, will not improve the children's well-being. Of course, there are many reasons—moral, economic, and social—why a society should be concerned about relieving the poverty of both adults and children, reasons that are unrelated to the impact of poverty on the physical, academic, social, and emotional well-being of children. We have focused only on the "children's" issues.

Public Programs to Help Support Children

Both in California and the nation, a number of programs have been established to help promote the well-being of children living with parents who earn little or no income. These include direct cash grants to parents who are not working and programs that provide needed food, shelter, and medical care to both parents and children. To the extent poor children are eligible for such programs, and their parents use the support, the well-being of the children should be enhanced.

As shown in Table 4-12, many poor children are not receiving the benefits of these programs. The parent(s) of less than half of all poor children receive income from AFDC, slightly more than half of all poor children participate in programs designed to help provide them with adequate food, and only 70 percent are covered by health insurance. (Overall, only 78.6 percent of all California children were covered by health insurance in 1985–86; this is a decline from 89.7 percent in 1980–81). The figure for those living in public housing is quite low—15.6 percent. Given the conditions in many public housing projects, poor children may be better off living in other types of housing; in fact, the increase in the percentage of children in public housing between 1980 and 1985–86 (8.9 to 15.6 percent) may be an indication of deteriorating conditions for children.

In terms of public assistance, California's poor families differ in some significant ways from poor families in the nation as a whole and in the other large states. A greater percentage of California's poor children are covered by AFDC and health insurance than in the nation as a whole, although a few states cover more children. In contrast, a smaller percentage receives food stamps and free school lunches, and lives in public housing (Table 4-12).

It must be recognized that the low use rates reflect, to some degree, the choice of some parents not to use these systems. Use varies significantly by ethnic group. The reasons for these differences are not clear; in some instances, they may reflect differences in eligibility based on family structure, refugee status, or other factors that vary along ethnic lines. For some programs, they may reflect negative attitudes among some ethnic groups towards using certain aspects of the welfare system. When parents choose not to use certain services, we cannot know how that decision ultimately affects their children's well-being.

Future Trends

The outlook for reducing poverty among California's children without significant new policies is not bright. In fact, several trends indicate that the problem may get worse. These trends include the increased proportion of births to single parents and evidence that the generation of women and men about to enter their childbearing years have, on average, poor educational preparation for employment.

In the past few years, a number of new programs have attempted to address some of the problems. Efforts to improve child support collection, expand education and job training for single mothers (GAIN), and reduce teenage pregnancy are underway. We do not have, as yet, evidence on the success of most of these initiatives. Unless they are successful, there will be more poor children and the gap between poor and other children will grow. The fact that this income difference will also divide children along racial and ethnic lines makes the need for an adequate policy response all the more pressing.

TABLE 4-12 Poverty Children Who Are Covered by Public Assistance and Receive Subsidized Lunches, Food Stamps, and Health Insurance, California and the Nation, 1980–81 to 1985–86

	1980–81		1985–86	
	California (1,490)	United States (18,755)	California (1,908)	United States (18,453)
Receive public assistance (AFDC and other)	47.8%	46.2%	51.5%	45.8%
Covered by health insurance (including Medicaid)	70.1	66.1	72.3	67.8
Receive food stamps	54.1	62.3	48.9	61.9
Receive free or reduced-price school lunch	58.9	61.7	59.3	61.1
Live in public housing	8.9	16.4	15.6	20.8

SOURCE: Current Population Surveys.

Chapter 5

Child Care and Early Childhood Programs

By W. Norton Grubb

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Responding to change seems to be difficult: women have been moving into the labor force in substantial numbers at least since the 1890s, but the adequacy of child care remains a serious public issue nearly a century later. The idea of educating children earlier than age 6 has been around since the 1830s, and seems to be rediscovered in every era, including our own, but its implications for governmental programs have largely eluded us. Child care is an area in which several schools of thought and many sources of support—child advocates, child developmentalists, working women, educators, and even the business community (which now touts the economic benefits of earlier intervention)[1]—could combine to create a consensus about what needs to be done. But such a consensus has been missing, and the result has been confusion and inaction even as the demand for child care continues to increase.

The sense of inadequacy and stalemate holds true even in California, which has the best-developed policy toward child care and early childhood programs of any state in the nation. The first and most powerful irony concerning child care and early childhood programs in California is that *despite California's leadership in providing such care, most informed observers and advocates feel that the current system does not meet the needs of most children or parents.* True, we have much to be proud of, and many exemplary programs exist. California provides more state money for child care programs than any other state, and in California policymakers and providers have become more sophisticated about child care than in other states. Yet the supply of child care remains insufficient, resources (including state support) are generally considered inadequate, variations in quality are too great, and many substandard child care facilities exist. The state's "policy" is often chaotic and inconsistent, and there is still little consensus on some of the basic issues of purpose and method.

Some of the debates over early childhood programs reflect well-worn differences between liberals and conservatives. But the challenges facing early childhood programs are more varied and more complex than that. Many problems result from the contradictory goals, some of them adult- rather than child-focused, of early childhood programs. Other problems reflect deep uncertainties, widely shared, about what is best for young children and what the role of professionals and parents should be. The low status of child care remains a serious problem, along with the fact that, despite its long history, it is still in its infancy as an issue of public policy.

This chapter analyzes California's child care policies and programs and their impact on the well-being of children. It begins by summarizing what is known about the child population in various child care and early childhood programs. Although the chapter focuses primarily on child care, including school-age child care, some information on preschool programs is also included. The next section poses a difficult but central question: what might it be like to focus on *the condition of children in child care*—on the well-being of children themselves—in formulating early childhood policy? We explore the issue of quality in order to clarify what elements of quality are important and how state policy can (and cannot) affect quality. The third section examines the private sector in child care. The fourth describes publicly subsidized programs. The fifth section reviews recent efforts to diversify funding in child care by developing support from local government and from employers. The final section presents some alternative ways of improving the system and the well-being of children in the system.

Who Is "in Care"?

As for most aspects of child care, basic information about the numbers of children in early childhood programs is either incomplete, out of date, or missing. The problem is compounded by terminology. The term "child care" generally refers to care of children while their parents are working; it is used to refer primarily to care of children too young to go to school, but with the rise of school-age child care (providing care before and after school for children ages 5 to 10, and occasionally up to age 14) "child care" now encompasses a larger age span, from infants through adolescents. However, the term "child care" does not usually include preschool programs—half-day programs that have often been intended to provide educational experiences to children ages 2 through 5, but that do not cover the working day. (Head Start is generally a half-day preschool program, and California also subsidizes the similar State Preschool Program.)

The use of child care is almost entirely a function of working parents; very few nonworking mothers use significant amounts of outside care. However, in less than a third (28.6 percent) of California families the father works full time and the mother stays at home. In slightly more than a third of California families (37.2 percent) both parents, or the only parent, work full time. In the remaining families, one or both parents works part time. In 1986, roughly 1.3 million children up through age 5 lived in families in which the work patterns made use of child care likely (Table 5-1).

Many types of child care arrangements exist. They fall along a rough continuum, with children cared for in their own homes by an unpaid relative perhaps the least formal arrangement. Care by a nonrelative in the child's own home is somewhat more complex, and may involve payment. Care in another home, or family day care, is more formal still, and involves the state because family day care homes are supposed to be licensed. Center-based care is the most formal.

Since most children are cared for in unsubsidized and unlicensed settings, the only way to find out about the use of child care is through surveys of random samples of the parent population. The best information comes from a survey of 1,234 California households with children under age 14, performed in 1985 by the Gallup Organization for the Governor's Child Care Task Force. This survey asked parents about their child care arrangements, their satisfaction with the arrangements, and their opinions about the quality of those arrangements.[2] The most basic findings are summarized in Table 5-2. From this survey it appears that approximately 1,140,000 children in California were in care in 1985, including 201,000 up through age 2, 359,000 from ages 3 to 4, and 581,000 from ages 5 to 10.[3] (These results include children up to age 13, and both working and nonworking parents.) The totals indicate that only 15 percent of children are in centers, with another 13 percent in family day care (paid or unpaid). However, 46 percent of children with both parents working, and 40 percent of those with a working single parent, are in some sort of care outside the home; and 52 percent of all children ages 3 to 4—the prime age for preschool day care—are in outside care.

Not surprisingly, infants and toddlers are less likely to be cared for outside their homes than older children; 18 percent of toddlers are in centers or family day care, while 11 percent are cared for in their homes by nonrelatives. The remainder are cared for in their homes by relatives. Approximately one-third of children ages 5 to 10 are in a center or a family day care setting, presumably before and after school; very few 11- to 13-year-olds are in formal care.

Although some racial and ethnic differences affect the use of care, the differences are hard to interpret. Black households report using more center-based care and family day care than do white households, probably because they are more likely to be eligible for publicly subsidized child care. Conversely, Hispanics use less outside care. Hispanic mothers are less likely to be employed outside the home than others, and are less likely to be single parents. These results are consistent with the finding that Hispanics are more likely to use relatives and friends rather than government-sponsored or social services.[4]

Finally, some differences in child care use are related to family income. Higher-income families are more likely than lower-income families to use center-based care and paid family day care.

TABLE 5-1 Numbers and Percentages of Families in California, by Work Status and Age of Children, 1986

	All families	Families with Children Ages 0–2	Families with Children Ages 0–5	Families with Children Ages 6–14
Total families	3,834,649	1,186,446	2,140,001	2,200,273
Single parent				
Working full time	551,798	88,974	400,102	321,660
Working part time	118,849	13,450	50,015	81,120
Not working	377,213	129,395	234,431	230,761
Two parents				
Both working full time	912,810	233,303	395,550	518,547
Both working part time	22,741	8,262	14,060	10,778
One working full time, one working part time	416,418	111,133	183,900	257,366
One working full time, one not working	1,096,862	452,663	647,935	602,515
One working part time, one not working	90,867	34,491	56,085	55,364
Both not working	247,092	114,775	157,923	122,162
Percentages				
With both parents working full time	38.2%	27.2%	37.2%	38.2%
With both parents working full time or part time	52.7%	38.4%	48.8%	54.1%
With at least one nonworking parent	47.3%	61.6%	51.2%	45.9%
Total children				
Of specified age	—	1,360,368	2,660,53	3,344,378
With both parents working full time (estimate)	—	370,020	989,717	1,277,552
With both parents working full time or part time (estimate)	—	522,381	1,298,339	1,809,308

SOURCE: Figures derived from the 1986 Current Population Survey by Nanci Anderson for the Assembly Office of Research.

TABLE 5-2 Types of Child Care Used by Any Child During a Typical Weekday

	Two Parents			One Parent		Race/Ethnicity			Income		Ages of Children			
	Total Families	Both Working	One Working	Working	Not Working	White	Black	Hispanic	Over $18,000	Under $18,000	Infants only (0–2)	Preschool only (3–4) (5–10)	Elementary only (11–13)	Preteens only
In child's home														
By parent or other relative	95%	90%	100%	82%	98%	94%	92%	97%	96%	94%	95%	92%	93%	95%
Self-care	3	6	—	6	1	4	—	1	2	4	—	—	2	10
By another child	1	2	—	2	0	1	1	1	1	1	—	—	—	—
By nonrelative, nonresident	4	8	1	7	0	4	1	4	2	4	11	3	2	2
By nonrelative, resident	1	1	1	1	0	1	—	—	—	—	—	—	—	—
In another home														
Unpaid	6	10	2	10	9	6	13	7	6	6	3	9	6	2
Paid (family day care)	7	14	1	9	2	8	13	5	2	9	7	12	10	1
Center-based care	15	22	9	21	3	18	22	8	10	16	8	31	16	3

Note: Percentages total more than 100 pervcent because of multiple responses.

SOURCE: The Gallup Organization, *California Child Care Final Report*, prepared for the Governor's Child Care Task Force, 1985.

Of course, the causality of this relationship is unclear: households with higher incomes are more likely to have one or two working parents and therefore have more need of care. It is difficult, especially with a sample as small as the one in the Gallup survey, to disentangle the separate effects of employment, income, and cultural preferences on the use of child care.

Results such as those in Table 5-2 are often cited as evidence that many parents *avoid* placing their children in care outside the home. In every category, care by parents or adult relatives is the most common arrangement; furthermore, 54 percent of two-parent families where both parents are working, and 60 percent of single-parent families where the parent works, report no use of care outside the home. Even allowing for the fact that many of these families have school-age children who do not need care, these figures suggest that many families develop arrangements whereby their children will not have to be in care outside the home. This interpretation is supported by interviews with parents, which find that many parents put together patchwork arrangements, combining their work schedules and occasional care by relatives, so that their children need not be in formal child care.[5] Patchwork arrangements are facilitated by the fact that about one-third of mothers with young children work part time and, of those families in which both parents work, one-third have at least one parent who works part time.

However, although some parents may prefer their children to stay at home, in general it is impossible to infer anything about parental preferences from information on child care arrangements. Parents' choice of child care is the result of their preferences, but is constrained by what they can afford and what is available in their particular area. Parental preferences may be especially limited because the "market" for child care is not homogeneous. Places for 3- to 5-year-olds are unsuitable for infants and toddlers, and school-age care is much different from preschool care. In addition, the care must be convenient to both home and work and must conform to work schedules. All these requirements must be satisfied before parents can deliberate over what kind of child care they truly prefer.

As a measure of how supply can limit child care possibilities, in the Gallup survey 42 percent of families not using family day care reported that such care was unavailable. Similarly, 32 percent of those not using centers said center care was unavailable. These results indicate that the availability of care may be a problem for as many as half of all families not using centers or family day care. Cost, scheduling, and location are problems to others.

Of course, the preferences spoken of are those of parents, not children. Children do not opt to be in care. However, if they are in care, their satisfaction is undoubtedly related to the nature and quality of the care. The following section examines this issue.

The Search for Quality

If a truly child-oriented policy (rather than one dominated by urgings to reduce welfare spending, support maternal employment, or attend to other adult goals) were developed, then all programs would be of high quality, since a child-oriented policy would presumably be one that meets all the needs of children. Much current interest in child care as a compensatory mechanism for low-income children stems from the positive long-term results of the Perry Preschool Program, an experimental program of very high quality (and very high costs).[6]

Attention to quality helps defuse one of the persistent debates over child care—whether or not care outside the home is detrimental to young children. Although part of the opposition to child care arises from hostility to women working, many parents still feel that young children develop best when reared at home. However, current evidence indicates that child care of the appropriate kind and quality is not detrimental to children, although of course poor care can be harmful, and there is still disagreement about the appropriateness of outside care for infants.

Thus, the quality of available care assumes major importance for children and their parents. Almost no one believes that the majority of early childhood programs or child care settings maximize a child's development. Some do not even meet children's basic developmental needs. Compromises over resources, shortages and high turnover of qualified child care professionals, and restriction of parental choice, all make the quality of child care less than it could be.

Quality has been only one of many concerns among proponents of child care. Historically, early childhood programs have had at least four sources of support. One of the earliest was the "compensatory" model, whose intention was to provide education at an earlier and earlier age to compensate for the deficiencies of parents. Although this approach motivated efforts of philanthropists to establish infant schools in the 1830s and 1840s, it remained largely dormant until the development of Head Start in the 1960s and the recent revival of interest in compensatory preschool programs. A more persistent approach has been the "welfare" or "custodial" model, providing child care to poor children so that their mothers might work their way off welfare. The "developmental" approach, emerging from the nursery school movement of the 1920s, insisted that the goal of programs should be the social, emotional, and cognitive development of the child, rather than the employment of the parent. Finally, the "feminist" approach has insisted on the availability of child care so that women can participate fully in employment.

Other rationales for providing child care have emerged from time to time. For example, Works Progress Administration (WPA) nurseries were established during the Depression as a way to employ teachers, and the Lanham Act Centers were federally funded during World War II to facilitate the employment of mothers in the war effort. Yet these efforts have usually focused on adult concerns or social problems rather than on the conditions of children.

Partly as a result of these different bases of support, there has been a progression of concerns in child care, first with *availability* of care (especially for welfare mothers), then with *affordability* (particularly for a new generation of working mothers), and finally with *quality*. To be sure, the "developmental" model has always stressed the need for well-trained staff and carefully planned activities and curricula. But in recent years the rapid increase in the numbers of mothers working, and the dominance of the "welfare" model in federal child care policy, have made availability the major focus and relegated issues of quality to second place. If it were possible to focus for a change entirely on the well-being of children, then the quality of programs— and the funding, education, and regulation necessary to ensure high quality— would take precedence.

Assessing Quality

It is one thing to emphasize quality, and it is quite another to develop mechanisms for ensuring quality. The dimensions of quality in early childhood programs are often hidden; young children are not very articulate about their troubles, so problems caused by an untrained caregiver, an overcrowded program, or a dangerous facility can often be dismissed as the result of a bad day or the normal traumas of growing up. The problem may simply not be recognized.

However, some dimensions of quality are well understood and easy to measure. These factors were identified in the most thorough study of day care, the National Day Care Study. Adult-child ratio is one of these dimensions; the study found that quality deteriorated past a ratio of 1:10, a ratio that has since become the outer limit of recommendations.[7] Group size is another factor: even with adult-child ratios fixed, smaller groups are preferable to larger groups because distractions and interruptions are fewer. A third factor is training; training teachers about early childhood education and child development enhances the quality of programs.

Another component of quality is salaries. Salary levels affect children in two ways: low salaries make it less likely that people with extensive knowledge of child development will become caretakers, and low salaries contribute to high turnover. Given the importance to young children of stable relationships, high rates of turnover are likely detrimental to them. Nationally, salaries of child care workers are extremely low, with full-time teachers averaging about $12,500 (in 1986 dollars), which is barely above the poverty level of $11,203 for a family of four.[8] Salaries are not appreciably higher in California. Various community surveys have resulted in estimates ranging from $10,680 in Los Angeles to $14,658 in northern Alameda County. Average salaries are higher in publicly subsidized programs ($16,580); in school-based children's centers salaries average $21,660. The Child Care Employee Project in Oakland has estimated that approximately 20 to 30 percent of child development teachers leave their positions annually, with rates as high as 53 percent in some areas. Low salaries are largely responsible (Table 5-3).[9]

Other aspects of quality are more elusive and difficult both to observe and to regulate. Differences between good and mediocre facilities are subtle, and most casual observers— including most parents— have not been trained in what to look for and thus cannot readily tell the difference between adequate and poor facilities. In a well-run center, there is an enormous amount of hidden structuring. The physical space is carefully arranged to provide a variety of activities so that children in one area will not interfere with those in another; areas for active play are separated from those for quieter activities and privacy. Activities are carefully paced throughout the day and are geared to the rhythms of children coming and going and to fluctuating levels of children's and teachers' and energy. Although most good centers devote some time to relatively formal cognitive development, most of the "curriculum" is embedded in games, toys, and activity centers within classrooms, and is designed to allow children to initiate activities.

In such settings, teachers circulate constantly, interacting with children, engaging nonparticipating children in activities, resolving conflicts, and anticipating problems before they develop. Because early childhood educators emphasize the importance of socializing children to group settings and cooperative behavior, correcting selfish or uncooperative behavior is important to the basic "lesson" of child care, not merely to classroom management. The corrections of skilled teachers are gentle and reinforce a child's positive self-image, rather than being harsh or demeaning. The best teachers are warm and loving, but warmth alone is insufficient; an effective teacher has a capacity we might term "educated caring," that is, he or she understands the developmental stages and thoughts of young children and responds to them intelligently as well as lovingly. A well-run child care class, bustling with activity, seems to be running itself, but in fact the influence of the teacher is pervasive though hidden.

In contrast, a poorly run center with untrained teachers can be a terrible place for children. The idea that teachers must actively engage children in planned activities is missing in many centers, so many children spend large amounts of time unfocused, drifting among activities in ways that leave them both bored and frazzled. Without constant monitoring, some children may become wild, especially if they are bored, and they may respond in a dangerous or violent manner. Under these circumstances, untrained teachers— who have no real idea why things get out of control— may be pushed to the limits of their patience. Then correction becomes harsh and belittling, and scolding and even spanking become more frequent.

If the center has cut corners on adult-child ratios— not difficult to do, especially with lax enforcement of licensing— then the chaos, inattention of teachers, management problems, and harsh direction and punishment become even more serious. Children in such centers may come home both bored and overactive, feeling badly about themselves and hostile toward other children,

TABLE 5-3 Salaries for Early Childhood Teachers and Aides

Salaries in Current Dollars	Full-Year Salary, 1986 Dollars
West Los Angeles (1983):	
Teachers $5.47/hour	$12,822
Aides $4.39/hour	10,291
Santa Cruz (1983):	
Teachers $5.63/hour	$13,197
Aides $5.01/hour	11,744
Pasadena (1983):	
Teachers $5.15/hour	$12,072
Aides $3.84/hour	9,001
Northern Alameda County (1984):	
Teachers $6.79/hour	$14,658
Aides $4.80/hour	10,362
Los Angeles area (1986):	
Teachers $5.34/hour	$10,680
Aides $4.38/hour	8,760
California: all publicly subsidized centers	
Teachers $8.29/hour (1986)	$16,580
Aides $6.24/hour	12,480
California: school-based Children's Centers	
Teachers $10.83/hour (1986)	$21,660
Aides $7.45/hour	14,990
National Day Care Study (1977):	
Teachers $3.36/hour	$12,820
Aides $2.59/hour	9,882
NAEYC survey (1984):	
Teachers $5.67/hour	$12,456
Assistant teachers and aides $4.55/hour	9,979
Current Population Survey (1984):	
Child care workers $9204/year	$10,247
Prekindergarten and kindergarten teachers $15, 648/year	17,422
1980 Census (1979 incomes):	
All child care workers $3,877/year	$ 6,308
Year-round full-time child care workers $6,617/year	10,765
Title XX programs (1981):	
Teachers $8,258/year	$11,680
Aides $7,259/year	10,267
Perry Preschool (1964–65):	
Teachers $6,435/year	$25,542
Public school teachers	$24,482
Average elementary teacher (1983–84)	21,452

Note: In addition, teachers receive benefits averaging 25 percent of salaries, while aides receive benefits averaging 22 percent. Other studies do not provide information on benefits.

but unable to determine where the blame lies or how to articulate to their parents what goes wrong. Untrained child care workers, unable to recognize different developmental stages and insecure about their own abilities to manage a class, are likely to cover up any systematic problems, so parents may receive no real information about their child's day, or about problems that arise. Children in such programs may be safe (at least most of the time), and kept warm and fed; but the kinds of development, of both capacities and self-esteem, that take place in a good center are missing, and daily life may be miserable.[10]

The number of children in poor care is not known. No studies directly measure the impact of child care on most children, and children are not interviewed. There are no studies that look at a large number of settings. It might be argued that such studies are not needed since if parents are satisfied, their children are probably benefiting.

How satisfied *are* parents with the care they use? The Gallup poll, like most other parent surveys, found high levels of satisfaction. Of all parents using care, 66 percent reported that they were "very satisfied" with their child care arrangements, and 30 percent reported that they were satisfied; only 3 percent reported being unsatisfied, including 2 percent of those using centers and 6 percent of those using family day care homes. Some moderately higher levels of dissatisfaction were expressed with the flexibility of scheduling (8 percent), and dissatisfaction with cost rose to 9 percent among single parents and those using centers.[11] However, the results about satisfaction are generally consistent across surveys; if they can be believed, then child care in California has been remarkably successful.

At the same time, 21 percent of households using child care reported problems severe enough to require some change in their child care arrangements, including 28 percent of households with two working parents, 31 percent of those with single parents, 35 percent of families regularly using centers, and 48 percent of those using family day care. Because changing child care usually involves considerable time in searching for a new arrangement, as well as dislocation for the child, parents are unlikely to change child care as readily as they might switch toothpaste; the frequency of change is therefore an indicator of very serious problems with child care. Among the reasons for these changes, the most frequent responses included undependable or untrustworthy caretakers, disagreements with caretakers, inadequate supervision, and the type of care provided. Only 11 percent cited inconvenient hours and 9 percent cited cost, suggesting that the quality of care rather than more neutral aspects of care arrangements are responsible for changes.

The high proportion of parents who have had serious problems with their child care arrangements seems to contradict the high levels of satisfaction reported. One explanation is that people are reluctant to admit that they are dissatisfied with their current situation, since dissatisfaction may imply a personal failure. In the case of child care, the issue of leaving children in order to work is still a subject of great anxiety to mothers (and fathers, too), despite increased maternal employment rates over the past two decades and ever more literature confirming that child care per se is not harmful to children.[12] No parent wants to admit that his or her child's day care is inadequate, and there are many mechanisms by which parents can rationalize events that may be indicators of problems: children (and caregivers) all have "bad days," children have "separation anxiety," children have to be socialized to group care and may resist, children are temporarily "acting out" or "testing limits," children are at a "difficult stage." All of these are arguments by which parents can explain away or dismiss evidence of dissatisfaction by children with child care arrangements that the parents cannot easily monitor. It is quite possible, then, for parents to express high levels of satisfaction with child care while still experiencing problems serious enough to cause them to change child care arrangements rather frequently.

What is left, then, is the kind of equivocation that is so common in child care. Parents report high levels of satisfaction with their child care arrangements; but at the same time large numbers of parents have had problems substantial enough to force them to change their child care arrangements. Evidently there is a great deal of child care in California, but some of it may not be very good for children.

Although substantial consensus exists about the elements of high-quality care, it is not so easy to develop mechanisms for assessing or guaranteeing such care. In part the problem is one of resources– high-quality care is expensive. But the problem goes beyond cost. Serious disagreements have arisen about who shall do the regulation– a state agency, professional associations of providers, "consumer" organizations, or individual parents. Moreover, no consensus exists about the goals of child care. The implications of these problems are discussed in the next two sections.

Private Sector Child Care

As previously indicated, in 1986 about 1.14 million children in California were in child care. At the same time, the State Department of Education reported that about 108,000 children were served in publicly subsidized programs.[13] Even in California, which provides the largest public subsidies for child care of any state, only a small minority of children in child care (9.5 percent) are served by the public sector. The vast majority receive private care.

The variety of privately provided child care is simply enormous– certainly more substantial than the publicly supported child care described in the next section. At the upper end of the spectrum are laboratory schools run by universities, in which renowned child developmentalists develop carefully monitored programs with little regard for cost. Such efforts are essentially experimental, and difficult to replicate. More typical of the best programs would be those centers with dynamic directors, stability, and a secure funding base (a middle-class neighborhood, for example, or a private agency such as a church, a YMCA, a private social service agency– even a corporation). Excellent centers often develop strong reputations in their communities and long waiting lists to match. Their intrinsic quality may be reinforced by the loyalty and support of parent groups– a rich resource.

At the opposite end of the spectrum are centers and family day care homes that range from mediocre to abusive. A scandal over sexual abuse charges at the McMartin Preschool in Manhattan Beach has fixed one image of child care in the public mind. Although not a totally isolated phenomenon, it seems unlikely that it occurs in more than a very small number of settings.[14] Mediocre programs are more common but less obvious. In these settings, children are tended by untrained and low-paid caregivers who have little idea what to do with groups of demanding, energetic children. These caregivers may be inattentive, bored, indifferent, hostile, or simply too overwhelmed with their own problems to pay much attention to the children in their care.

Whether particular types of facilities are more likely to be of low quality is controversial. Family day care homes, in which a woman cares for up to six children (a small family day care home) or twelve children with the help of an aide (a large family day care home) have been targets of special concern, because caregivers are usually untrained, often unconnected to any networks of help, and frequently poor and under stress. Some observers feel that proprietary child care, including the franchised day care centers, is especially likely to be of poor quality, because the profit motive leads directors to cut corners on salaries, adult-child ratios, and materials. Proprietaries have also been charged with using a marketing approach to child care, developing centers that appeal to parents but may not be good for children.[15] The main association of private child care providers in California, the Professional Association for Childhood Education, has until recently not accepted franchised programs as members, and has worked to differentiate the quality of its programs from what it considers to be the low quality of some franchise operations. Other people defend franchised centers, which have reportedly been expanding dramatically in California, saying that they increase the options available to parents and are responsive to the "market."

Church-based day care facilities are generally thought to be of good quality, since many churches provide some in-kind contributions (rent and utilities) if not cash subsidy, and sometimes see child care as one of their missions. But some horror stories about church-based facilities have surfaced, and churches have on occasion challenged the licensing power of the state as violating the separation clause.

Given the great variety of private settings, the key question for those concerned about the condition of children— parents and policymakers alike— is how high-quality child care can be obtained at affordable prices. Table 5-4 presents information on the costs of child care in California. The figures must be interpreted cautiously: they represent costs to parents, not total costs. They exclude donated resources (including volunteer time and free rent and utilities provided by many churches and schools), which have been found to average about one-seventh of direct expenditures. These figures confirm that infant care costs more than preschool care, and that most family day care costs less than center-based care. In addition, the costs show enormous variation both within and among different counties of the state.

TABLE 5-4 Average Child Care Costs, 1986

	Statewide Mean	Statewide Standard Deviation	Lowest County Mean	Highest County Mean
Child care centers				
Full-time infant care, per week	$80.66	$24.58	$40.00	$115.75
Full-time preschool care, per week	60.20	16.84	37.50	82.67
Part-time infant care, per hour	2.25	0.83	1.00	2.97
Part-time preschool care, per hour	1.68	0.63	0.92	2.15
After-school care, per hour	1.94	0.66	1.00	2.44
Family day care homes				
Full-time infant care, per week	$63.43	$15.07	$45.20	$81.03
Full-time preschool care, per week	60.55	14.51	42.77	94.27
Part-time infant care, per hour	1.89	0.64	1.05	2.18
Part-time preschool care, per hour	1.82	0.62	1.03	2.46
After-school care, per hour	1.80	0.60	1.03	2.24

SOURCE: California Child Care Resource and Referral Network, *California Inventory of Child Care Facilities, Area and Regional Market Rate Costs by County and Statewide Totals for Ages and Hours of Care*, 1987.

For children under age 18 in California, median family income in 1985–86 was about $27,200. For parents at this income level, preschool care, which averaged $3,023 per year, consumed 11 percent of income. One common rule of thumb is that middle-income families can afford to spend about 10 percent of income on child care, so by this standard many parents— probably a majority— have a difficult time affording child care at prevailing costs in California. The results, very often, are shortages of care, substandard care, or both.

Licensing

At present, the state's responsibility for ensuring quality in the private sector is limited to licensing day care centers and family day care homes. Under current laws, the State Department of Social Services (DSS) licenses all centers (facilities with more than twelve children), small family day care homes (a caregiver and up to six children) and large family day care homes (a caregiver, an aide, and up to twelve children).

However, licensing has generally been interpreted as setting minimum health and safety standards, rather than assuring the quality of care. Licensing requirements focus primarily on adult-child ratios. Adult-child ratios run from 1:4 for children through age 2 to 1:15 for children ages 6 to 12. In addition, center directors must satisfy requirements that can be met with various combinations of education and experience, and teachers in day care centers must have twelve units of early childhood education in specific course areas. Also, there are space requirements, health-related requirements pertaining to bathrooms and kitchens, safety provisions relating to exits and fire precautions, and a required fingerprint check for care providers designed to prevent sex offenders from being hired. Child care facilities also must meet local government requirements, by obtaining use permits from local zoning boards, building permits from local planning agencies, and fire permits from local fire marshals.

It is generally agreed that these requirements, to the extent that they are enforced, guarantee only minimum quality. There is substantial evidence, moreover, that they are not enforced very effectively. The main enforcement strategy available to those charged with licensing is pointing out violations and negotiating corrections. Except in cases of clear abuse, DSS does not have the power to close a child care facility, but must refer licensing violation cases to county district attorneys, who are often so burdened with serious crime that licensing violations have low priority. DSS can levy fines, but these are trivial ($50 in most cases), and many repeat offenders find it cheaper to pay fines than to correct violations. Even for centers, the licensing regulations cannot be easily enforced against those operators who willfully violate them. Licensing may still produce real effects, both by setting standards for conscientious day care operators and by discouraging prospective operators who might want to open truly abysmal centers. But, because of enforcement problems, the fact that a setting is licensed is not a guarantee to parents even of safe conditions.

Although current licensing regulations are minimal, considerable opposition to adopting more stringent regulations exists on economic, pragmatic, and ideological grounds. For example, adult-child ratios can be easily regulated but higher ratios are expensive; thus fiscal conservatives seeking to lower the cost of care and those who consider the "custodial" model adequate have been pressing to lower ratios in subsidized programs. Lowering total group size is an inexpensive way to increase quality (unless physical modifications to a facility are needed), but group size is unregulated in California. Increasing salaries in the private sector of child care is beyond state powers.

Moreover, ratios, group sizes, and salaries, necessary though they may be, cannot affect the more subtle aspects of quality, especially the training and experience necessary for skilled teachers of young children. The requirement in licensing regulations for preparation in early childhood education is an attempt to foster such abilities; but in practice the variety of early childhood training varies greatly. Centers often receive exemptions from these requirements, enforcement is poor, and in any event, family day care is exempt from all such requirements. The state's policy toward these aspects of quality is largely laissez faire.

The cost of additional regulation is only one barrier. Another persistent problem is the issue of state versus parental responsibility. Many people feel that parents have a right, and an obligation, to choose the type of care appropriate for their family. Thus, proposals by DSS to develop quality-rating systems have been resisted with the claim that judgments about quality are too personal and too specific to individual parents' preferences and children's temperaments for the state to make these decisions. Governor Deukmejian's Task Force on Child Care declared that "child care is ultimately the responsibility of the parent" and therefore eschewed addressing the issue of quality. This view has also been adopted by officials in DSS. Even some child care advocacy groups have resisted a greater role for DSS, although their concerns focus on the lack of expertise among DSS staff with regard to measuring quality.

In fact, with regard to family day care, some groups advocate reducing state regulation. One common proposal has been to replace the state's licensing procedures with a registration mechanism, in which providers would certify that they meet certain standards and parents would have the basic responsibility for verifying that a home is satisfactory (with the help of agency advice about what to look for). Advocates of registration argue that parents in fact have this responsibility now because so few homes are licensed, and that it would be better to include "underground" homes in some aspect of the state's regulatory structure, rather than let them remain completely independent. Other children's advocates have raised the specter of possible serious increases in child abuse under the proposed system, despite evidence from other states that this has not happened. As a compromise, California initiated a pilot registration project in Alameda County, but the results were unpersuasive to opponents of registration. The upshot has been a stalemate: neither side can persuade the other, and licensing of family day care homes continues.

Other licensing battles have involved the qualifications of teachers. Advocates of good child care typically want to increase requirements for training in early childhood education for two reasons. First, there is evidence from the National Day Care Study that such training is related to higher quality care; and second, better training is associated with greater professional standing and higher pay. Some providers have just as consistently opposed efforts to increase requirements, sometimes claiming that day care requires warmth and love more than training, but also on the grounds that increasing requirements will drive up costs and price some families out of the market (and reduce profits, especially for small centers).

Ultimately these debates, so crucial to the well-being of children, are frustrating, because the state's regulatory powers (establishing minimum standards to protect health and safety) can neither provide the additional resources that higher quality often requires, nor give advice and counsel that might improve the child care offered by inexperienced or ignorant providers.

The issue of regulating child care can be stated as follows: *licensing is crucial, because the safety of children must be assured; but licensing alone cannot improve the quality of care or address the loftier goals for children to which parents, early childhood professionals, children's advocates, and many providers and legislators aspire.* Ironically, advocates for children have been caught in the middle, because the unavoidable tradeoff between cost and quality has no ready *regulatory* solution. At a time when child care resources are scarce, many parents will not be able to afford to pay more for care, and the pool of well-qualified child care teachers will be small because of poor pay. Consensus is made even more difficult by uncertainty over what constitutes quality. The debate sometimes takes the form of principled discussion about what is best for children and what research and experience prescribes, and sometimes reflects the self-interest of professionals and providers.

Although many people believe that the state should not regulate the private sector or limit parental decisions, there is major public financial investment in the private sector. As the following section describes in greater detail, state child care money supports a variety of local providers, including both governmental agencies (school districts, a few county offices of education, and county welfare agencies) and private agencies. Indeed, most of the growth in publicly subsidized child care since the 1960s has been in private facilities, not in school districts or other public agencies. In 1986–87, 41.4 percent of public funding was subcontracted through private agencies, while almost all subsidized child care in the early 1960s was provided by the school-based Children's Centers.

Subcontracting to private providers has been based in part on a decision to expand the diversity of publicly funded care by allowing community-based organizations to participate in public programs. It is also an opportunity to try to promote high-quality care throughout the state. With public funding has come more stringent regulations (at least in some programs), greater cost accountability, and more comparisons between the public and the private sector on costs, salaries, conditions, and quality.

However, support of the private sector has not been motivated primarily by concerns over quality. Various initiatives have self-consciously used the private sector to lower the costs of publicly provided child care, relying on conventional rhetoric about the greater efficiency of the private sector. Examples include AB 3059 (1976), which provided additional funding for various novel programs, and current proposals by the governor's office to expand funding in the state's voucher-like program (the Alternative Payment program). Whether the "efficiency" mentioned includes concerns over quality is questionable. Moreover, although there may have been differences in costs between public and private providers, such differences have been eliminated by pressure on the costs of public programs since the 1970s.[16]

Resource and Referral (R&R) Agencies

Licensing is not the only mechanism available to improve quality in the private sector. Another is the use of local resource and referral (R&R) agencies. These were initially funded in 1976 as pilot programs and have since been expanded so that every county now has at least one R&R agency. (The large urban counties, such as Los Angeles and Alameda, have more than one, in order to provide geographic coverage.) The first duty of R&R agencies is to provide information to parents about centers and family day care homes, but their responsibilities have grown to include:

- Educating parents about the characteristics of good care (although they usually will not discuss the quality of specific programs with parents)
- Providing training and technical assistance to providers
- Mounting efforts to increase the supply of child care
- Easing the burden of applying for licenses and local permits
- Expanding the resources available to child care by lobbying local governments, local business, and foundations as well as the state legislature.

In educating parents and providing technical assistance to child care facilities, R&R agencies can improve the quality and increase the supply of private sector care in ways that are less punitive and threatening than licensing, and that complement regulation. Unfortunately, such efforts also carry substantial costs, and under the press of limited resources the efforts of R&R agencies to improve quality and increase supply have varied among counties. Nor has the state ever made a concerted effort (or provided the resources) to use R&R agencies systematically in these ways; no coherent state policy blends the state's instruments—regulation, advice provided by R&Rs and the State Department of Education, and direct funding—in any well-planned way.

One other current effort to improve child care quality is a model based on a nongovernmental approach. This model relies on certification and accreditation through professional associations. The National Association for the Education of Young Children, the principal professional association in early childhood education, has recently established a mechanism to accredit programs. NAEYC trains "validators," individuals with extensive backgrounds in early childhood education, to evaluate programs according to an extensive checklist. Unlike the usual process of credentialing teachers, which examines formal education, the NAEYC accrediting process examines teachers *in* child care facilities. Centers must pay $250 to $750 (depending on program size) to receive NAEYC accreditation, but the desire of centers to be recognized for their quality and teachers to be recognized for their professional abilities have been sufficient attraction for many centers. Thus far, 38 California programs have been accredited, and 156 are now in the accreditation process. Although this is a small fraction of the 7,820 licensed centers, NAEYC reports growing interest as centers learn about the program.

Similarly, the association of private child care providers in California, the Professional Association for Childhood Education, now requires "assessment" of all its members. This assessment is less stringent than accreditation, but more demanding than licensing. This association for many years has also discussed an accreditation system, although it is currently undecided whether to develop its own system or to use that of NAEYC.

These assessment and accreditation approaches are more acceptable than state efforts to develop quality indicators because they provide guidance and advice, rather than simply developing standards to be met, and because they base decisions about quality in professional associations on institutional self-interest in improving quality. Although this approach is promising, it now affects only a small percentage of children in care.

Thus, we are left with substantial concern over the quality of the care many children experience in the private sector. At present, state regulation is only of limited value. There is reason to doubt the ability of many parents to judge adequately the quality of programs, and R&R agencies are not accessible to all. Moreover, even if we could assume that most parents had the capability of choosing well, and would focus primarily on their child's needs and not on their own, the substantial problem of availability remains.

General unanimity prevails among observers of child care that high-income parents in areas of the state with rich supplies of child care (Alameda County, for example, or the Palo Alto area) have substantial choice. But in most areas, especially urban areas, the majority of parents are likely to find themselves offered only a few reasonable choices, and will face lengthy waiting lists for many good programs. The problem is especially acute for parents with unusual work schedules, for children with special needs (for example, disabled children), and for the working poor.

Like almost every sector in the United States, child care is an example of a mixed economy at work: a combination of public and private providers, in which public funding and regulation coexist with a predominance of private funding. Compared with the public schools or social services such as foster care, the extent of public participation is still small; but the legitimacy of public participation is no longer an issue. Given the changes in family structure and work patterns, policymakers across the political spectrum must recognize that public concern with child care quality and availability is needed if we are to enhance the well-being of children. The real issue is what standard of care society is prepared to accept for children.

Public Funding in California: Crisis in Paradise

One problem in private sector child care that no amount of minor intervention can resolve is affordability for low-income parents. A few simple numbers illustrate the dilemma. As previously indicated, in 1986 the average cost per week of full-time child care for preschool children was $60.46, or $3,023 for a full year. For a family of four at the federal poverty level of $11,203 gross income per year, fifty weeks of care for one child would have consumed 27 percent of income; two children in care would push the family's child care bill above 50 percent of their income. By the rule of thumb that expenditures above 10 percent are excessive, and that 5 percent of income may be appropriate for families of moderate income, low- and moderate-income families are hard-pressed by child care costs.

As a result, low-income families have always been a high priority for government child care subsidies. (The only higher priority is abused and neglected children.) The emphasis on poor children is a confluence of several different arguments. One historically persistent view is the "welfare" rationale for child care: without government support, low-income families will be forced to abandon employment and go on welfare, raising welfare costs and providing poor examples to their children and others. The second school of thought has emphasized the child's development and the value of early childhood education to social, emotional, and cognitive development. In recent times, many child care advocates have emphasized the role of early education in compensating for the apparent academic deficiencies of low-income children.

The equity argument—that poor families ought to benefit first from the state's programs—has also attracted some support, although, unlike the "welfare" and the "developmental" rationales, the equity argument fails to specify why child care should be eligible for government subsidy when many other necessities are not. These rationales coalesce most readily to justify developmentally oriented child care for low-income children, but they coexist uneasily: those emphasizing welfare savings have supported low-cost (and low-quality) child care, while those emphasizing developmental objectives have insisted on the need for high quality but have often supported half-day preschool programs (like Head Start) that do not serve the needs of working parents.

California provides more state support for child care, and funds a richer variety of programs, than any other state in the nation. This has been true ever since the end of World War II: California was the only state to continue public funding of the Lanham Act centers, which had been established during the war to enable mothers to work in war-related industries. Currently, as Table 5-5 indicates, California provides roughly $320 million in direct state funds for child care. In contrast, the other most generous states spent much less. Texas provided $36 million in 1985–86 for a low-quality, half-day, prekindergarten program for disadvantaged four-year olds. New York spent $20 million for a compensatory preschool program. Illinois spent $12 million; Massachusetts, $10 million; South Carolina, $8.7 million; and New Jersey, $8 million—all for new preschool programs. Other states spent much smaller amounts, usually for pilot projects involving half-day preschool programs.[17] Most of the direct federal government subsidy for child care has come from the federal government through the Social Services Block Grant.

California not only provides far more state money than any other state, but it also supports a richer variety of programs. These include publicly funded programs, run by school districts, nonprofit agencies, and private providers. Different programs are available to parents depending on their income. The following programs are listed below to give an idea of the variety of concerns that underlie child care policy in California.

TABLE 5-5 Total Estimated Governmental Resources for Child Care, 1986–87 (in millions of dollars)

	State Funds	Federal Funds	Total
Direct and Indirect Support			
State Department of Education programs	$314.7	$ 4.5	$319.2
UC, CSU, community college funds	6.2	0	6.2
GAIN support	30.0[a]	0	30.0
Child Care Food Program	4.5	60.3	64.9
AFDC income disregard	8.1	6.6	14.7
Head Start	0	98.2	98.2
Work Incentive Program (WIN)	0	0.4	0.4
Refugee Assistance Child Care	0	1.5	1.5
Support Services			
DSS licensing	15.8	0	15.8
Child Development Programs Advisory Committee	0.2	0	0.2
Tax Mechanisms			
State tax credit	20.1	0	20.1
Federal personal tax credit	0	335	335
Federal corporate tax credit	0	20	20
Total	$399.6	$526.5	$929.2

[a] Allocation for child care; actual expenditures may be only 20–25 percent of this amount.

Note: Many of these figures are estimates, and must be interpreted with caution.

Program Descriptions

One group of programs serves low-income families, usually defined as those whose income is below 84 percent of the state's median income. These include the following:

- *General Child Care—Public.* Most of these facilities are centers operated by public school districts, although a few are operated by county superintendents of schools. A few districts operate systems of family day care homes rather than centers. All these programs operate for the entire working day, but—partly because of their location within schools—they have a self-consciously developmental focus. Critics sometimes charge that their location in the public schools has made them more "school-like"; that is, more didactic in their approach, more concerned with strictly cognitive development and such school-oriented tasks as reading and math.
- *General Child Care—Private.* These facilities are centers operated by private rather than public agencies. Funding for these programs, begun in 1972, represented a decision to fund child care in a greater variety of agencies, including programs operated by churches, YMCAs, and community groups.
- *Center-Based, Title 22.* These are centers operated by private community-based organizations. These centers adhere to the Title 22 licensing requirements rather than the more stringent Title 5 regulations required of other centers funded by the State Department of Education. (Title 5 requires a teacher-child ratio of 1:8 instead of 1:12 for 3- to 5-year-olds. Also, Title 5's teacher requirements are higher.) Title 22 centers are intended to provide child care at a lower cost, so that more children can be funded than in the centers operating under Title 5.

- *Family Day Care Homes.* These are also funded as a way of providing child care both in a greater variety of settings and at lower cost, since family day care is generally thought to be cheaper than center-based care (contrary to the figures in Table 5-4).
- *Alternative Payment.* This program is an effort to apply the logic of vouchers to state funding mechanisms. Eligible families are entitled to a subsidy based on their income, and in theory they can use this subsidy at any licensed facility; thus parental choice can operate more freely than in other programs, where eligible children must apply to specific centers. Payments are made directly from local administering agencies to child care providers, rather than giving parents vouchers for the amount of the subsidy; thus this program is usually described as a "vendor" program rather than a pure voucher model. This program has attracted considerable support on the grounds that it allows greater parental choice and flexibility and costs the state less than other programs. (Actually, evidence that the Alternative Payment program costs less is rather weak.)[18] In addition, Alternative Payment is sometimes the only feasible way to subsidize care, especially in rural areas where establishing centers would not be economical or in other cases in which there are very few providers with vacancies (for example, for children with special needs or parents with unusual work hours). On the other hand, voucher-like mechanisms require that there be sufficient child care in a community and good information available to parents, so the existence of R&R agencies able to inform parents and stimulate supply is crucial to the use of vendor-voucher mechanisms.

Another group of programs provides child care to specific groups of children. This group includes the following programs:

- *Campus Child Care.* This program supports child care for parents who are students in the University of California, California State University, and California Community College systems. Eligibility is based on the same income guidelines governing general child care, so that only low-income students qualify. Usually these programs are operated either by student associations or by college administrations, which may provide space and use the centers as laboratory schools for students in child development programs.
- *State and Federal Migrant Programs.* These facilities care for the children of migrant farmworkers. The centers are open for varying lengths of time in different areas depending on growing and harvesting seasons. State and federal funds are combined, and this remains one of the few child care programs in California with any federal funding.
- *JTPA (Job Training Partnership Act) Child Care.* This program provides a match of one dollar of Social Services Block Grant (SSBG) funds for every dollar a local service delivery area (SDA) allocates to child care for JTPA enrollees. The original intent was to provide incentives for SDAs to allocate more resources to child care, since child care services in federal training programs have often been inadequate. Initially the funds allocated for this program were seriously underused, but after a startup period the program appears to be operating smoothly, providing more child care for JTPA enrollees than would otherwise be the case. However, only twenty-two of the state's fifty-one SDAs, serving about one-third of single-parent JTPA recipients, have successful programs, so coverage is far

from universal.[19] As the matching funds come from SSBG funds, the entire program is funded from federal sources.

- *School-Age Parenting and Infant Development (SAPID).* This program includes both a child care component (to care for the children of high school parents so they can complete their high school education) and a parent education component. These programs are operated by fifty-five school districts and six county offices of education.
- *School-Age Community Child Care (SACCC).* Often referred to as "the latchkey program," this program provides before- and after-school care for children between 5 and 14 years of age. (In practice, most of the children enrolled are in kindergarten through third grade.) Enacted in 1985 along with California's workfare program Greater Avenues for Independence (GAIN), the latchkey program was intended to stimulate the supply of after-school care for workfare clients, most of whom have school-age children, and to respond to mounting concern about young children being left alone after school.[20]
- *Severely Handicapped Program.* This program provides special services for children whose handicaps are so severe that they cannot be cared for in regular child care programs. Special services include therapy, guidance, and parental counseling.

Abused and neglected children receive first priority in most state-funded programs; however, high priority does not assure placement when there are no openings, as is frequently the case. Two other programs are designed to provide care to abused and neglected children:

- *County Welfare Programs.* This program provide funds from the State Department of Education to county welfare offices; services are provided for abused and neglected children and for children of working welfare mothers.
- *Protective Services (Respite Care).* These programs provide funds to R&R agencies, county offices of education, and other local agencies that help children who are in danger of being abused or neglected. Respite care is used when no other funds are available for such children.

All these programs provide child care during the working day. In addition, California supports a relatively large preschool program. The state preschool program was instituted in 1965, at about the same time as Head Start, in order to provide educational programs for low-income children from ages 3 to 5, so they would be better prepared for school. Unlike the other programs funded by the State Department of Education, Head Start is a half-day program only. Often local programs combine state preschool funds and federal Head Start funds, since the purposes of the two programs are so similar.

In addition to funds allocated through the State Department of Education, California provides support for child care in several other indirect ways. One is the "income disregard" mechanism of Aid to Families with Dependent Children (AFDC). The welfare grants of employed AFDC recipients are reduced as their earnings increase, but expenditures on child care and some other work-related expenses can be partially ignored, or "disregarded," in calculating this reduction. In effect, the income disregard mechanism is similar to a voucher, in that AFDC parents can be indirectly reimbursed through their welfare grants for the child care they choose. In addition, federal funds support half of these costs through the federal contribution to AFDC.

California's workfare program, GAIN, provides other child care subsidies through the welfare system. AFDC parents with children ages 6 and older must enroll in GAIN (unless they are disabled); those with children under age 6 may volunteer for GAIN. The parents are entitled to support for child care expenses incurred as a result of participating in the program. The GAIN program is administered by county welfare offices, which typically use purchase-of-service agreements with providers for child care, and often work closely with local R&R agencies to identify child care facilities. Under this plan, a GAIN client can select virtually any form of child care, and can even use unlicensed care and care by relatives.

The other major mechanism of indirect state subsidy is the tax system. Until 1988, the California income tax allowed a credit for child care equal to 10 percent of the federal credit for those with adjusted gross incomes of $20,000 or less and 5 percent for others. The federal credit varied from 20 to 30 percent of child care expenditures depending on income, with a maximum total expenditure of $2,400 for one child or $4,800 for two. Thus the state credit ranged from 1 to 3 percent of child care expenses. A low-income family in California spending the maximum $2,400 for one child was eligible for a federal credit of $720 and a state credit of $72; however, neither of these credits is refundable, so if the family paid no state income tax the credit was worth nothing. A moderate-income family (with income over $20,000) received a federal credit of $480 and a state credit of $24. The total value of the tax credits has been estimated to be $20.1 million in 1986.[21] As of the 1988 tax year, the California credit was raised to 30 percent of the federal credit, worth from $144 to $216. Even at this expanded level, the state tax credit is so small relative to the high costs of child care that it seems a largely symbolic gesture.

Federal child care resources and state early childhood programs are relatively limited compared to other states. The largest source of federal funding is the federal tax credit, which amounted in 1986 to approximately $335 million.[22] Like the state credit, the federal credit is nonrefundable, so that low-income families who pay little or no federal tax do not benefit; the result is that, unlike other forms of state and federal aid, the federal credit favors moderate- and high-income families. The irony of the federal credit is that a funding source so indirect and seemingly inequitable, and which is an afterthought of tax policy rather than a carefully developed aspect of a coherent federal policy toward child care, is nevertheless the largest single source of governmental support—larger than all California State Department of Education programs combined, and far larger than direct federal support for Head Start.

The other major source of federal revenue supports Head Start, which in California is almost always a half-day program and is often combined with the state preschool program. Limited federal funding supports the migrant child care program and the JTPA child care program, and of course partially supports expenditures through the AFDC system (including income disregards).

It is interesting in light of California's substantial commitment of state funds, that relative to other states, federal revenues for child care in California are low. This is due to a state decision in the late 1970s to replace federal funds with state funds. In most states, Title XX of the Social Security Act (now the Social Services Block Grant) has provided funds for child care aimed at current or potential welfare recipients.[23] In the 1970s, federally supported child care was required to meet the Federal Interagency Day Care Requirements, which specified adult-child ratios of 1:5 for children ages 3 to 4, more stringent than the Title 5 requirements of 1:8. California therefore substituted state funds for federal funds in order to provide child care at a lower cost using Title 5 ratios, and applied federal funds to other social services without restrictive regulations. Since then, child care in California has been relatively independent of federal policy.

The decision to forego federal funds is a vivid example of the potential tension between quality and quantity in child care. California followed a strategy that accepted higher adult-child ratios in order to fund a maximum of spaces. No evidence demonstrates a difference in the well-being of children in settings where the ratio is 1:8 rather than 1:5. More adults undoubtedly provide better supervision and more individual attention. Yet unless more public funds are allocated to child care subsidies, supporting lower ratios will mean that some families will not receive any subsidy. Perhaps they would provide care themselves, rely on relatives, or place their children in unlicensed settings with much worse ratios. We just do not know.

Assessing the Effectiveness of California's Child Care Program

Two elements must be examined in assessing state efforts to provide child care to families unable to afford it. It is not enough simply to examine program quality; it is also necessary to discover (1) whether programs meet the demand for child care, and (2) if not, what happens to children in families that do not receive help. Do they wind up in poor care? Must their parents forego work in order to care for them? If so, is this better or worse for the children? By what standard should we measure "better" or "worse"? For example, some children might be happy that their parents had to give up working in order to care for them, while others may receive poor care at home because their parents would prefer to be working. It is also possible that children cared for at home would miss the benefits that child care offers in the way of social and academic development.

Unfortunately, data on the condition of children cared for by state-supported providers are no more available than are data on children cared for by entirely private providers. Nor are data available on the kind of care received by children who are eligible for state programs but denied support because of limited funds. More surprisingly, perhaps, relatively little is known about how well the various programs are functioning.

We know, however, that despite the fact that California seems to have a "model" child care policy (relatively generous with state funding, creative in its development of alternative programs, and serious in its effort to improve existing programs), most advocates and observers of the system see serious deficiencies, at least with regard to quantity of placements. For example, The Little Hoover Commission concluded that "California is experiencing an availability crisis in quality child care." This crisis is signaled by inadequate subsidized child care spaces for the working poor and for special population groups such as low-income and minority families, families in high-density urban areas, disabled children, and children at risk of abuse or neglect. The Governor's Child Care Task Force found and reported shortages of subsidized care for children of the working poor, infants, disabled children, school-age children, and children whose parents have unusual work schedules. The task force also criticized the lack of consistent state policy. A Senate Office of Research report, *Caring for Tomorrow*, made similar charges of shortages. Among advocates and providers of child care, the dominant complaint has been the inadequacy of state funds. The most troublesome paradox facing child care in the state, then, is that *California provides more funding for a greater variety of child care programs than any other state; yet public subsidies are widely viewed as inadequate.*

Need for Child Care

Several reasons are given to explain why shortages seem so pervasive despite the relative generosity of state funding. First, no matter how generous the state's support seems to be in comparison to other states, it is still small relative to need. To be sure, "need" for subsidized child care is an elusive concept, and many estimates have been exaggerated. Nevertheless, there is little doubt that many needy families do not receive aid through available programs. One conservative method of estimating need relies on the current definition of children eligible for public subsidy. In 1986-87, approximately 383,000 infants and toddlers up to age 2 lived in families where both parents, or the only parent, worked and where the parents' income qualified them for public subsidy; however, public programs served only about 8,500 children at that age level. According to these estimates, then, public programs met only 2.2 percent of the child care needs of eligible children up to age 2. Similarly, public programs met the child care needs of only 17.9 percent of children ages 3 to 5 who were eligible and in need of care, 8.7 percent of all children up through age 5, and 7 percent of the need for children ages 6 to 10 (who would use after-school care).[24] (These estimates of participation rates undoubtedly err in several ways. For example, not all working parents may want or need child care, which may mean the figures are too high. Yet participation rates probably underestimate the numbers of low-income children whose parents are working; and rates include children in preschool programs, which are inadequate for children of parents working full time.)

Other measures of need can be devised for particular groups of children. For example, state child care programs aimed at teenage parents enrolled 2,435 children in 1984–85; yet 32,221 children were born to women ages 18 and younger in California in 1985, and perhaps another 30,000 children ages 1 to 5 had teenage mothers. Clearly the state program for teenage mothers serves only a small fraction of those in need.[25]

The number of severely handicapped children served in the state in 1985–86 was 166, compared to estimates of about 21,000 handicapped children under age 5. The migrant program provided care for 2,758 children in 1985–86, but several hundred thousand migrants were working within the state. Even if parents of many of these children prefer to have their children cared for by relatives, it is still clear that existing programs provide care to only a handful of the children who might be served.

Despite the relative generosity of California's subsidy program, the gap between need and availability undoubtedly has grown over the past ten years. This growth is due to two factors: (1) in real dollars, the amount of state funding has declined, and (2) demand, or need, has risen.

Funding Problems

With regard to funding, two significant changes have affected the funding base. Proposition 13 effectively ended local revenues for child care in 1978; and beginning in 1981 federal support ended. At about the same time, then, two major sources of public revenues collapsed. Local revenues had been important to the Children's Centers, which prior to 1978 received local tax revenues; and local revenues were only partially replaced by state revenues in the state "bailout" of 1979. Perhaps equally important now, continuing limitations of Proposition 13 on local governments mean that most local initiatives to improve child care are forced to abandon the option of direct funding.

In terms of federal resources, when the state substituted its own funds for federal funds, as discussed earlier, it limited the influence of federal funding on state programs. But declining federal revenues have put additional pressure on state revenues elsewhere in the social service budget, and have forced child care advocates to abandon any hope of turning to Washington.

The reduction of local and federal funds has meant that state government has been the only source of public revenues during the 1980s. In contrast, the diversity of funding during the 1970s meant that the burdens of child care were distributed among different funding levels. The principle of diversified funding, which has operated relatively well in K-12 education, is an attractive idea for child care as well, since different levels of government could concentrate on somewhat different aspects of child care policy (as they do in education). However, such a policy would require both a substantial change in federal policy and a reversal of Proposition 13.

The change in the funding base has resulted in a decline in the *real resources* committed to publicly subsidized programs. Table 5-6 presents expenditures in publicly subsidized programs since 1977-78. Although there have been substantial increases in public expenditures for subsidized programs (an overall increase of 55.6 percent between 1977-78 and 1986-87, for example), these increases have not been sufficient to keep pace with inflation, which increased 94.2 percent over this period. As a result, total expenditures in real terms (that is, adjusted for inflation) actually fell 20 percent over this period, and expenditures in established programs (excluding the new latchkey program and the JTPA program) fell 24.4 percent.

The decline in expenditures in publicly subsidized programs seems to have occurred in two stages. The first occurred after Proposition 13, when the school-based programs lost their ability to raise local property taxes. Expenditures in school-based programs fell from $124.3 million in 1977-78 to $90.3 million the following year, largely because local tax revenues fell from $40.8 million to $8.5 million. The state, as part of the Proposition 13 "bailout" of local governments, increased its subsidy, but this was insufficient to compensate for the decline in local revenues. The second stage of the decrease in real spending came during the 1980s, as expenditures failed to keep pace with inflation; real expenditures in established programs fell 7.3 percent between 1982-83 and 1986-87. The feelings frequently expressed by child care advocates— that subsidized programs have been consistently squeezed by the failure of expenditures to keep pace with inflation— are certainly correct.

Declining revenues appear to have resulted in fewer children being served. It is more difficult to document trends in the number of children served by public programs, because of both incomplete data and changes in the way children are counted. Counting methods may or may not differentiate between children participating part time or part year and those participating full time. Total enrollment figures will be higher if many part-time and part-year children are counted. The figures on enrollments, displayed in Table 5-6, are unreliable because definitions of enrollment have changed over time; however, these figures suggest that enrollment declined slightly since the 1970s in every program except Alternative Payment.

The total number of children served in all public child care programs was reported to be 109,084 in 1979-80 and approximately 108,000 in 1985-86, including 14,000 in the school-age child care program. The overall number of children served has been roughly constant, but only because of the addition of the school-age child care program; for those programs established earlier, the number of children has declined. Uncertain as they are, these figures corroborate the sense that public programs have been dwindling, not only in real expenditures, but also in the numbers of children served.

Increasing Demand

The problems caused by declines in real expenditures are exacerbated because they occurred at a time of increasing demand. Although the child population declined in the 1970s, it has been increasing since 1980. Thus the drop in the proportion of children served is considerably greater than the small decline in absolute numbers would seem to indicate.

Not only is the total number of children in the population increasing; with the continuing increase in maternal employment and the adoption of the GAIN program, the "need" for child care has also steadily grown. Increases in maternal employment over the past two decades have been so substantial that they have overwhelmed a system that has grown only incrementally; the system was essentially designed for the 1960s, when maternal employment was substantially less. Moreover, social conceptions of child care needs are constantly expanding. A good example of a newly discovered need is school-age child care. Five years ago

TABLE 5-6 Expenditures in Publicly Subsidized Programs Since 1977–78 (dollars in millions)

	1977–78		1978–79		1979–80		1982–83		1984–85	
	Expenditures	Enrollments	Expenditures	Enrollments	Expenditures	Enrollments	Expenditures	Enrollments	Expenditures	Enrollments
General child care (public)	$124.3	47,715	$90.3	36,685	$106.6	36,889	$118.5	28,537	$130.9	28,031
General child care (private)	24.9		27.3	11,368	39.4	15,590	40.1	11,528	44.6	10,992
Center-based, Title 22	4.2	7,327	11.4	3,549	c	c	8.3	2,473	8.6	2,275
Family day care homes	6.6			2,255	c	c	4.8	1,357	4.4	1,014
Alternative payment	5.2	4,129	5.1	4,802	6.9	4,755	15.8	4,734	18.2	4,850
Campus child care	4.8	3,493	3.7	3,295	6.1	3,001	5.2	2,203	5.8	1,283
State migrant	3.2	2,018	2.9	1,985	3.0	1,960	5.7	2,377	6.2	2,204
Federal migrant							2.0	355	1.9	335
JTPA	0	0	0	0	0	0	0	0	5.7	n.a.
School-age parent	1.3	510	2.8	840	2.4	873	4.4	n.a.	4.7	2,435
School-age child care	0	0	0	0	0	0	0	0	0	0
Handicapped	n.a.	n.a.	n.a.	n.a.	n.a	n.a.	0.6	176	1.1	250
County welfare	4.3	4,418	5.4	3,922	4.7	3,990	6.1	n.a.	5.6	n.a.
Protective services (Respite)	—	—	—	—	—	—	0.1	n.a.	1.0	n.a.
State preschool	24.5	23,800	24.5[b]	21,150	26.3	20,097	30.3	19,322	33.0	19,264
Resource and referral	1.9	n.a.	2.3	n.a.	2.5	n.a.	4.8	n.a.	6.5	n.a
Other	0	n.a.	0	n.a.	0	n.a.	3.8	n.a.	n.a.	n.a.
TOTAL	$205.2	93,410[a]	$175.7[a]		$197.9[a]	87,155	$250.5	73,042[a]	$277.1	72,934[a]

[a] Incomplete.
[b] Taken from figures on appropriations published by the Child Development Division, California State Department of Education.
[c] Included in general child care, public and private.
[d] No program in base year.

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TABLE 5-6 continued

	1985–86		1986–1987		Percentage Change 1977–78 to 1986–87		Percent Change 1982–83 to 1986–87	
	Expenditures	Enrollments	Expenditures	Enrollments	Nominal	Real	Nominal	Real
General child care (public)	$137.3	28,341	$136.4	29,112	9.7%	–43.5%	15.1%	–11.3%
General child care (private)	49.0	11,026	49.1	11,356	97.2	1.6	22.4	–5.6
Center-based, Title 22	7.4	1,861	7.9	1,764	88.1	–3.1	–4.8	–26.6
Family day care homes	5.0	1,137	5.3	1,143	–19.7	–58.6	10.4	–15.9
Alternative payment	22.3	4,881	25.7	6,421	394.2	154.5	62.7	25.4
Campus child care	10.1	2,058	10.2	1,301	112.5	9.4	96.2	51.1
State migrant	6.6	2,428	6.6	2,229	171.9	–11.5	15.8	–10.8
Federal migrant	2.1	330	2.1	n.a.			5.0	–19.1
JTPA	4.7	n.a.	2.5	n.a.	d	d	d	d
School-age parent	6.6	n.a.	6.6	n.a.	407.6	161.4	50.0	15.6
School-age child care	7.9	n.a.	15.3	n.a.	d	d	d	d
Handicapped	0.7	166	0.7	166	n.a.	n.a.	16.7	–10.1
County welfare	6.0	n.a.	6.1	n.a.	41.9	–26.9	0	n.a.
Protective services (Respite)	1.0	n.a.	1.0	n.a.	n.a.	n.a.	900.0	670.6
State preschool	35.2	19,264	35.5	19,221	44.9	–25.4	17.2	–9.7
Resource and referral	7.1	—	7.3	n.a.	284.2	97.8	52.1	17.2
Other	1.4	n.a.	0.8	n.a.	n.a.	n.a.	—	n.a.
Total	$310.3	71,492[a]	$319.2	71,113[a]	55.6 46.9 (excluding new programs)	–19.9 –24.4	27.4 20.3 (excluding new programs)	–1.8 –7.3

[a] Incomplete.

[b] Taken from figures on appropriations published by the Child Development Division, California State Department of Education.

[c] Included in general child care, public and private.

[d] No program in base year.

there was almost no mention of school-age care; parents developed ad hoc arrangements with recreational programs or older children, or simply left young children by themselves. Today it is recognized that "latchkey" children may suffer both emotional and physical injury unless care or some sort of support system is provided. In addition, child care has been affected by heightened awareness of the needs of disabled children, abused and neglected children, sick children, and children whose parents have unusual work schedules.

In more expansive times, child care advocates developed a vision of universal child care, a system analogous to the public schools in which all young children in need of care could be served. From this vantage, California's child care policy is still in its infancy, and the goal of universality is a very long way off.

Costs and Quality

Perceptions of the inadequacy of California's child care policy result partly from the effects of cost squeezes on quality. Although it is not easy to determine the impact of funding reductions on quality, it is reasonable to assume that, because of the decline in state support, some parents who do not receive state subsidies are placing children in marginal or bad settings. For children in subsidized programs, the situation is mixed. One problem in making any overall assessment is the great variety of programs in California. As previously discussed, there are many different child care programs in California, many with their own distinct emphases (for example, children of migrant workers, college students, or welfare recipients in the GAIN program). Each program has its own legislation, eligibility criteria, information requirements, and standards. Few of these programs have been evaluated—and no evaluation looks directly at the children.

Based on limited available data, programs administered by the State Department of Education seem to be, on average, of relatively good quality. The cost of the most common types of centers in 1985 was $2.39 per hour, or about $96 per week—more than 50 percent above the statewide average cost of full-time preschool care. Although serious problems arise with the comparability of the figures, publicly subsidized programs undoubtedly cost more: they use higher adult-child ratios, they pay teachers more, and they probably receive greater allotments of space and labor (especially in school district programs). In an area like child care, where resources have been so limited, the introduction of public subsidy allows all dimensions of quality to improve, but costs increase as well.

Public programs have been under constant pressure to reduce costs. Fiscal pressure on publicly subsidized programs began during the 1970s, when the state discovered that some school-based programs cost a great deal more than others, and began to squeeze the funding of high-cost programs. After Proposition 13, such efforts began in earnest, and the lack of cost of living adjustments (COLAs) during the 1980s has placed programs under constant pressure. Although people operating child care facilities have often been creative and resourceful, a number of cases suggest that quality has suffered as a result of budget cuts. "Lighthouse" or model programs have had their advantages whittled away, the wages of child care teachers have been under pressure, and the hope in many school-based programs of making the salaries of child care teachers equal to those of elementary school teachers has been abandoned. Some programs have used greater numbers of part-time teachers, since part-time workers do not receive benefits and are therefore less expensive; but such a policy means constant disruption for children as teachers come and go during the day. Other programs, particularly in school districts with union contracts, have been forced by the lack of COLAs to turn over their operations to community-based groups whose salaries are lower. In 1987, because of no COLAs, an unusually large number of child care providers voluntarily withdrew from the state's programs, and from the quality restrictions that accompany state funding.

Cutbacks in funding also have limited the state's role in monitoring programs. Theoretically, State Department of Education staff can provide technical assistance to publicly subsidized programs; the staff of its Child Development Division (CDD) are supposed to perform program quality reviews and to monitor programs. However, due to staff reductions, CDD staff are often unable to keep up with even the minimal reporting and contractual aspects of the contracts they administer. Technical assistance to programs, careful formulation of policy decisions, and monitoring and evaluation of local programs have become impossible. Program quality reviews now take place only every five or six years. In addition, despite the long history of the Department of Education's involvement with child care, the Child Development Division seems to be a low priority, most obviously manifested by constant reductions in staff. Moreover, the CDD often hires staff members who have transferred from other divisions within the State Department of Education or from other agencies in state government, rather than individuals who are trained in early childhood education or who have experience in child care; a declining fraction of CDD staff have worked in child care programs themselves. As a result, staff members who are knowledgeable about child care are deluged with requests for advice while other less knowledgeable members are avoided.

The degree to which these changes have affected the condition of children rests, in part, on one's conception of the purpose of child care and the needs of children. Those who view care largely as "custodial" do not view the somewhat lower adult-child ratios and the presence of staff without teaching credentials as a problem. They believe that children can be given a safe, supportive, interesting environment for less money than is now being spent. However, advocates of the "developmental" and "compensatory" rationales view the cutbacks with alarm. At a minimum, the cutbacks clearly make it much more difficult to provide an educational element to the programs; at worst, the cutbacks may result in less attention being paid to children's needs for emotional security and social development.

This lack of consensus about the goals of child care makes it extremely difficult to develop a coherent and well-administered state program. Another problem facing California's child care system is the ways in which the programs are structured: *every report on children has called for an integrated system of children's services and a coherent state policy; but administrative divisions and the "California model" of highly targeted programs make such an approach difficult.*

The lack of a coherent policy and program has been criticized by many organizations, including The Little Hoover Commission and the Governor's Task Force on Child Care. The problems caused by lack of consensus are exacerbated by the fact that responsibility for administering state-supported programs is divided between agencies with quite different points of view regarding the purpose of child care. In fact, there has been a long history of antagonism between the State Department of Education, which is responsible for most public funding, and the Department of Social Services, which administers AFDC (including the GAIN program) and licensing.[26] Recently, considerable hostility arose over the inception of the GAIN program: DSS staff, whose job it is to move welfare mothers off AFDC at the lowest possible cost, were impatient with the "educational" and "developmental" orientation of SDE, and felt that SDE programs were too expensive. SDE, on the other hand, has consistently tried to resist any efforts to undermine the quality of programs in order to simply provide more cheap child care, and SDE staff members tend to regard DSS as uninformed about child development.

In recent years, forces emphasizing cost cutting and custodial care seem to be in the ascendency. For example, the Governor's Task Force on Child Care recently questioned the placement of the administration of subsidized child care programs in a department whose primary focus is education. It suggested that goals appropriate to the education of children were not necessarily consistent with the basic goals of child care. A more in-depth review needs to be undertaken to determine which SDE programs are strictly child care and which are educational in nature. Consistently, the task force has adopted positions that would undermine the developmental in favor of the custodial model, including advocating the replacement of Title 22 regulations by Title 5 and the replacement of more expensive programs by cheaper programs under the Alternative Payment system.

As discussed earlier, the state has a particular obligation to provide for the sound development of children in the care of state-funded caretakers. It is reasonable to expect that such care be good, not just "minimal" or "adequate." Yet in the area of state-supported child care, it may be impossible to meet the highest standards. California has done much—but it is far from enough.

Perhaps the overriding lesson may be that adjusting to a new demographic reality is much more painful than anyone could have imagined; shifting to a world in which the majority of children who have yet to enter school are cared for in child care, in which everyone wants high-quality care, and in which many parents cannot afford the going rate for child care, will require a much greater commitment of public resources than now exists. The process may take decades; after all, the campaign to establish public support of elementary and secondary schooling occupied most of the nineteenth century, and the adequacy of funding remains a perennial issue for California and every other state. But until some equilibrium is established, child care advocates and legislators in California will be in the unhappy position of finding inadequate even the most generous increases in state funding, and the well-being of children in care will not be guaranteed.

The Desperate Search for Alternative Funding: Local Initiatives and Employer Support

The disparity between the need for child care subsidies and the amounts available from the state has set off a search for other resources. Advocates have turned to two sources in particular: local government and employers. Each of these presents real promise for providing some financing, and the participation of local government can also help to eliminate various barriers to providing child care. But as strategies for raising substantial amounts of funds, especially for low-income children, each is seriously limited.

The efforts to develop local policies for child care began in the 1970s. One city (San Francisco) established a Mayor's Office for Child Care, intended to serve as an advocate for child care and to ease the regulatory burdens on child care providers. More recently, a number of towns and cities, stimulated by the inadequacy of child care, especially for low- and moderate-income families not qualifying for public subsidy, have established task forces to study the local role in child care. Typically the reports from these task forces assess the local supply of child care and the nature of unmet need, and then outline available options.

The options for local governments include: educating the public about child care, facilitating the expansion of care by simplifying regulatory requirements or providing technical assistance, providing child care benefits to local government employees, expanding the amount of available care by including requirements to provide child care in planning ordinances, and funding child care directly from local revenues.[37] One popular approach has been to establish mayor's offices for children, child care coordinators, and continuing child care advisory groups. Several cities have passed ordinances requiring developers of new office buildings either to provide child care or to pay fees into a central account to support child care. Increasingly, local governments appear to be emphasizing the child care needs of low-income parents; for example, the city of Fremont has recently enacted a voucher system for low-income parents, supported by local tax revenues.

Despite evidence that more local governments are taking an interest in child care, the number of towns and cities that have taken any action so far are limited; most are wealthy suburbs. The fact that a very few cities are usually cited as models of what local governments can do is a hint that very few towns and cities have been able to follow their examples. The reasons are obvious: since Proposition 13, local governments have lost their taxing power, and raising revenues for what is essentially a new city service is nearly impossible. Furthermore, the finance equalization problem applies: especially for a new program, only the wealthiest communities are likely to be able and willing to spend local revenues for child care—and these are unlikely to be the communities where the greatest need exists for subsidizing low-income parents. Although a few communities can devise mechanisms to tax developers for child care, that is possible only where the demand for development is far greater than the supply of sites to be developed. Given the difficulty of raising funds, the most valuable aspects of local child care policy are likely to remain its educational and regulatory roles—helping to draw together communities around child care and easing the burdens of local ordinances.

The effort to stimulate employer-supported child care has also resulted from frustration with inadequate state government support. One approach has been to stress the economic value to employers of providing stable child care; the argument is that such care would help to eliminate absences, lost work time, and stress caused by shaky child care arrangements. This approach clarifies the connection between family life and employment, and some claim that employers should support child care to reduce the stress associated with working and parenting. An alternative has been to argue that child care expenses should be included among the benefits offered to employees. A popular form of employer support is the "cafeteria" plan, a method of funding that eliminates potential inequities between parents and nonparents by allowing employees to choose benefits from a menu of alternatives, one of which is child care reimbursement.

Still another approach has been for employers to support ancillary services, especially R&R services. For example, IBM has funded a network of over two hundred R&R agencies to provide special ("enhanced R&R") services to IBM employees. This effort provides benefits to the community at large as well, because it supports the fixed costs of R&R agencies. Other corporations have been involved in public-private partnerships to improve quality. The best-known example, the California Child Care Initiative begun by the BankAmerica Foundation, has focused on the shortage of good family day care homes. Through local R&R agencies, this program recruits and trains mothers to provide family day care; in 1985–86 it provided $575,000 in private funds and $315,000 in public funds for a concentrated and sustained effort to increase supply, building on the existing network of publicly supported R&R agencies. The program claims to have generated about 1,100 new child care spaces in 231 new licensed family day care homes in its first year.[28]

Employer support for child care has grown substantially. One attempt to canvass employers nationwide estimated 105 companies with programs in 1978, 415 in 1982, and perhaps 600 in 1984—a remarkable growth rate.[29] Others have estimated that perhaps 2,500 companies provided some kind of support as of 1986, although such guesses are imprecise (and partly motivated by boosterism) and "support" can indicate anything from company provision of a child care center to sponsorship of lunchtime seminars on parenting or very modest contributions to R&R efforts.[30]

A census of employers providing some form of child care support located about 120 programs in California. Approximately 61 percent of the employers who provide anything provide direct services by operating an on-site or off-site center; another 29 percent provide some form of financial support. Of the 120 employers, about 15 are government agencies, 7 are educational institutions, 41 are hospitals or other medical facilities, and a handful of others are private nonprofit organizations with a commitment to progressive policies. Thus only half the employers listed are conventional profit-making corporations.

Substantial energy and creativity have gone into developing new corporate approaches to child care. However, the evidence can also be interpreted as showing just how limited employer support really is. In a country with approximately 6 million employers, support by 2,500 companies is paltry indeed. The prospects for substantial additional support seem dim.

In evaluating the merits of public versus private programs, it must be remembered that a great portion of the resources companies invest in child care are actually government resources, especially federal support through the corporate and personal income tax codes. Contributions to child care are fully deductible, of course, and thus partially underwritten by tax writeoffs; the corporate tax also contains special depreciation incentives for companies that improve facilities for child care centers, and allows Dependent Care Assistance Plans, which permit employees to pay for child care with untaxed earnings.

Finally, most of the employer support for child care has come from large, highly profitable corporations. These companies pay the highest salaries, and low-income parents— those who are unemployed, or marginally employed, or without much work experience or education—are unlikely to be working in such companies. The most serious need for child care is for poor parents and the working poor, the groups for whom public subsidies are still inadequate; this need will never be met by the corporations that now support child care.

Future Trends: Will Child Care Enhance the Condition of Children?

Over the next few decades, the need for child care, and in particular for subsidized child care, will almost certainly continue to grow. Although the population of children ages 5 and younger will remain roughly constant from 1988 into the 1990s, more important trends affecting child care, such as the tendency of women to work, will not remain constant. Current projections indicate that the proportion of women with small children who work will continue to grow between now and the end of the decade.[31] As the numbers of working mothers continue to increase, new concerns within child care, such as the recently emerging attention to after-school care, will develop.

Evidence also suggests that the demand for subsidized care will continue to increase. Both poverty generally and the proportion of woman-headed families in particular (which translates into poverty because women are typically paid less than men) have been increasing in California; these increases will in turn generate larger numbers of young children whose parents cannot afford the full cost of child care. The demographic composition of California, with increasing numbers of Hispanics and East Asians, many of whom experience employment problems because of language and educational barriers as well as simple discrimination, will contribute to the need for subsidized care.

California faces, then, a clash between increasing demands for child care and inadequate resources. In order to meet the need for care, many policymakers are looking for more "cost efficient" (a euphemism for "cheaper") care. Cheaper care can only be achieved by two means: reducing adult-child ratios and further lowering wages of child care workers. Proponents of cost reduction are pressing for "custodial" care despite evidence that this approach is not good for children, and despite California's past success in developing model programs that merge the developmental and custodial goals of child care.

Can California have both quality and quantity? In thinking about the necessary reforms in California's child care system, at least three large areas need to be carefully considered. The first of these, unavoidably, is funding. It may be possible, with continued increases in demand and tireless pressure from advocates, to generate substantially greater state revenue for child care. However, while it is certainly possible to reverse recent declines in real revenues for child care, substantial new state resources seem

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unlikely because the amounts required to satisfy the need for subsidized care (however measured) are so enormous. A different approach would be that of diversification—combining state revenues with revenues from local, federal, and private sources. This approach would require changes in federal policies and in state laws that limit the ability of local government to raise revenues, as well as a new consciousness on the part of corporations and other private donors.

A second element to reconsider is the "California model" of providing child care through a plethora of categorical programs (each unrelated to and difficult to coordinate with the others) administered at the state level by the State Department of Education. One alternative, now being examined by the CDD, would consolidate the large number of existing programs into fewer programs. This would still provide a variety of facilities but without the administrative difficulties of the current system. In effect, California has had a system of centralized funding and diversified programs; it might be appropriate to have instead diversified funding and consolidated programs.

Another alternative would be to create local administering agencies responsible for assessing local need, making policy about the kinds of facilities most needed, increasing supply, coordinating regulation, improving quality, informing parents, and so on. These local bodies could be public agencies (for instance, city or county offices for children), or they could be consortia of governments (for instance, the service delivery areas of JTPA programs). Private R&R agencies could also become administrative agencies, since they already perform many of these functions and enjoy a level of trust that a public agency might not be able to develop.[32] If this approach involved R&R agencies in a conflict between their roles as supporters of child care providers and as administrators, a division of labor at the local level could be devised; local public agencies could be made responsible for administration and regulation while private R&R agencies could concentrate on information, advocacy, and the enhancement of quality.

Another approach would be to create a state children's office, which would be responsible for a variety of children's programs. For child care, this approach would redress the state administering agency's problem of low status with the State Department of Education, and would facilitate coordinating child care with other children's programs. But other current problems would not be helped by such an approach, and a new agency would inevitably suffer problems of low status simply because of its newness and because of the low status of children.

A third broad area to consider is the state's policy toward quality. Currently, this is nonpolicy, made up of bits and pieces of state licensing, support for R&R agencies, private accreditation efforts like those of NAEYC, the development of model efforts like the California Child Care Initiative, limited technical assistance from CDD, and local initiatives like child care coordinators. These efforts are combined with both good intentions and considerable disagreement about what quality means. One much-needed effort, then, would be to rationalize and coordinate this potpourri, to determine which aspects of quality are best handled by which kinds of agencies, to allocate responsibilities accordingly, and to coordinate the efforts to improve the quality of child care in the state. Such an approach would also make possible a broader assessment of the tradeoffs available in establishing quality. For example, it may be that reducing adult-child ratios somewhat, but increasing the support for technical assistance from R&R agencies and CDD, would both save state money and improve quality.

The time seems ripe to tackle these broad issues. If the current stalemate continues, California's child care system will become less and less adequate in meeting the needs of children, and California's legacy of exemplary programs and innovative approaches will dissolve.

Chapter 6

Education

By James W. Guthrie

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Schooling is important and pervasive. Virtually every responsible public official and informed citizen attests to the significance of education as a foundation for personal fulfillment and a civil and productive society. Moreover, intensified use of information, modern technological complexity, urban interdependence, and global economic competitiveness, render education even more important today and in the future than was ever the case in the past.

California legally recognizes education's significance and mandates school attendance. Consequently, 99 percent of California's children go to school. They may not want to go to school; they may not like school; they may not learn in school; and they may not stay in school. Nevertheless, almost no matter what else occurs in their lives, children enroll in school. Only a slender minority of children, generally individuals with severe abnormalities or uncorrectable handicaps, avoid being enrolled in a school. Schooling is one of the most pervasive conditions in the lives of children, in California as elsewhere throughout the nation.

Despite education's crucial significance and pervasive nature, beyond the level of legal mandates and public rhetoric, California generally does not regard the undertaking seriously. Schooling as an issue pales when compared to the public visibility and media attention accorded athletics, entertainment, business, politics, crime, gossip, and so on. The state's financial commitment to schooling reflects this sense of priorities. Measured against what children need to succeed in school, California makes only the most minimal investment. Regretably, the performance of large numbers of the state's students also reflects these priorities. In effect, California gets what it pays for— educational mediocrity.

This chapter is about California's children and the conditions of their schooling. The overall purpose is to describe and analyze education from the viewpoint of students. Thus, the chapter covers topics such as who goes to school, where, for how long, and with whom; what adults are in schools and classrooms with them; what students study, how they behave, and how well they learn; who governs this system and what California invests in the education of children; and finally what California students, their parents, and teachers think about their schools.

Before beginning this analysis, however, let us to provide a background against which to describe schooling conditions. What do children need in order to succeed in school? What should the state's requirements be, and what should public resources buy in order for the lives of young people to be fulfilled and for society's needs to be met?

What Do Schoolchildren Need?

Regrettably, there is no single formula to determine what children need from school. On important dimensions, children's needs will vary depending on their physical and social conditions. Nevertheless, beyond fundamentals such as health, nutrition, housing, and a secure home environment, reasonable people concur that the schooling of children is enhanced by conditions such as the following:

- A reasonably ordered and purposeful school environment in which a child feels physically safe and psychologically valued
- Instructional conditions in which performance expectations are explicit, comprehensive, coherent, and appropriately balanced between societal standards, parent preferences, and students' individual circumstances
- Sufficient exposure to instruction by competent and professionally concerned adults
- Access to appropriate instructional materials, such as paper, laboratory equipment, and libraries
- Regular, accurate, and instructionally useful performance assessments.

The following analysis of the school conditions for California's children will be made against these standards.

Who Goes to School?[1]

The factual answer to the question, "Who goes to school," as already suggested, is that almost every child goes to school. However, the reason why they go to school is far more complicated, at least legally, than one might suspect.

And Why Do They Go?—The Legal Underpinnings

The U.S. Constitution is silent regarding education; there is no national requirement that a child be schooled or even that schooling be publicly provided. Moreover, the Constitution's Tenth Amendment implies that schooling provided publicly ultimately is to be a state function. The California Constitution explicitly assumes state responsibility for public provision of schooling, and state statutes specify that a child must attend school from age 6 through 16, unless he or she has completed high school before age 16.[2] Providing school services to this population is an undertaking of awesome magnitude and complexity.

How Much Time Do They Spend in School?

Most children in California attend school longer than the compulsory minimum time period. Preschool, at age 4 or 5, through high school graduation, at age 17 or 18, is the norm. California's "school year" typically contains 180 days.[3] The length of the "school day" varies by grade level. In general, elementary students are in school from 8:30 A.M. until 2:00 or 2:30 P.M. During this period, they are expected to be engaged in formal instruction for approximately four and one-half to five hours. The remainder of the time is occupied with recess periods and lunch. Secondary students are generally in school for an additional hour of instruction, their school day typically concluding at 3:30 P.M.

The cumulative result of these attendance patterns is approximately 15,000 hours of schooling for the average California high school graduate. This is equivalent to the amount of time most adults spend at their work for nine and a third years. As much time as this may appear to be, however, it is less than most Asian and many European children will spend in school. Japanese schools, with which American systems are frequently compared, operate 220 days a year. Moreover, many Japanese students spend several years outside of school enrolled in privately offered additional instruction.

First, the Magnitude

California has slightly more than 5 million K–12 schoolchildren. This is far more than any other state. More than one out of every nine of the nation's kindergarten through twelfth-graders resides in California. The state's total K–12 public school enrollments (almost 4.5 million) exceed the aggregate school population of the twenty-two lowest enrollment states. Looked at another way, the total building capacity of every public school in the northeastern part of the United States—the six New England states, New York, New Jersey, and Delaware—would be needed simply to house California's current school population.

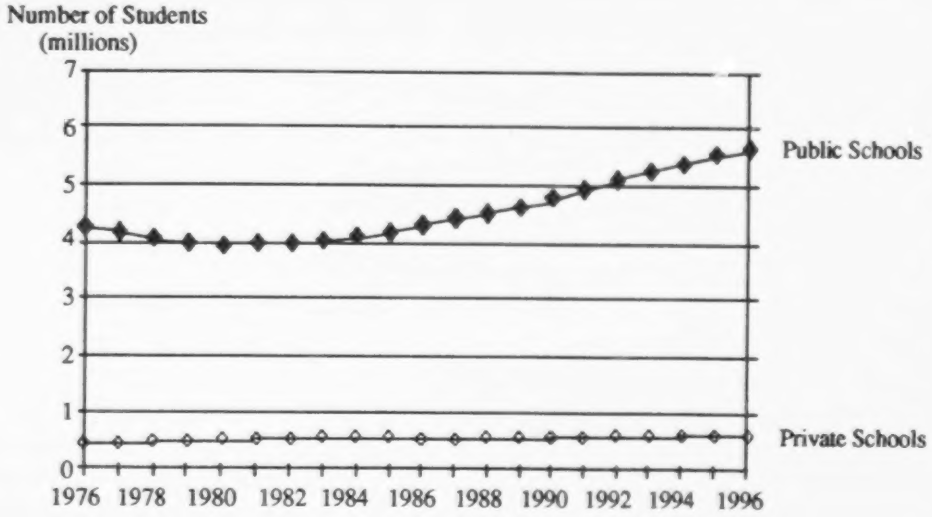
The large majority of California's 5- to 18-year-olds attend public school. Approximately 10 percent attend private schools,[4] one-third of which are religiously oriented (for example, Catholic, Seventh Day Adventist, or other Christian schools). The remainder of these institutions are nonsectarian academies. Figure 6-1 displays California K-12 enrollments actual and projected, for public and private schools.

Not only is California's school population large, it is also growing at an unusually rapid rate. Projections suggest that each of the next ten years will see annual public school enrollment increases of from 120,000 to 150,000 students. Indeed, the California current annual enrollment growth increment (the number of new students added from one year to the next) exceeds total K–12 public school populations in each of the eight lowest-enrollment states.

Second, the Location

Enrollments and enrollment growth are not evenly distributed

FIGURE 6-1 Trends in California Public and Private School Enrollment, 1976–1996



SOURCE: California Department of Finance.

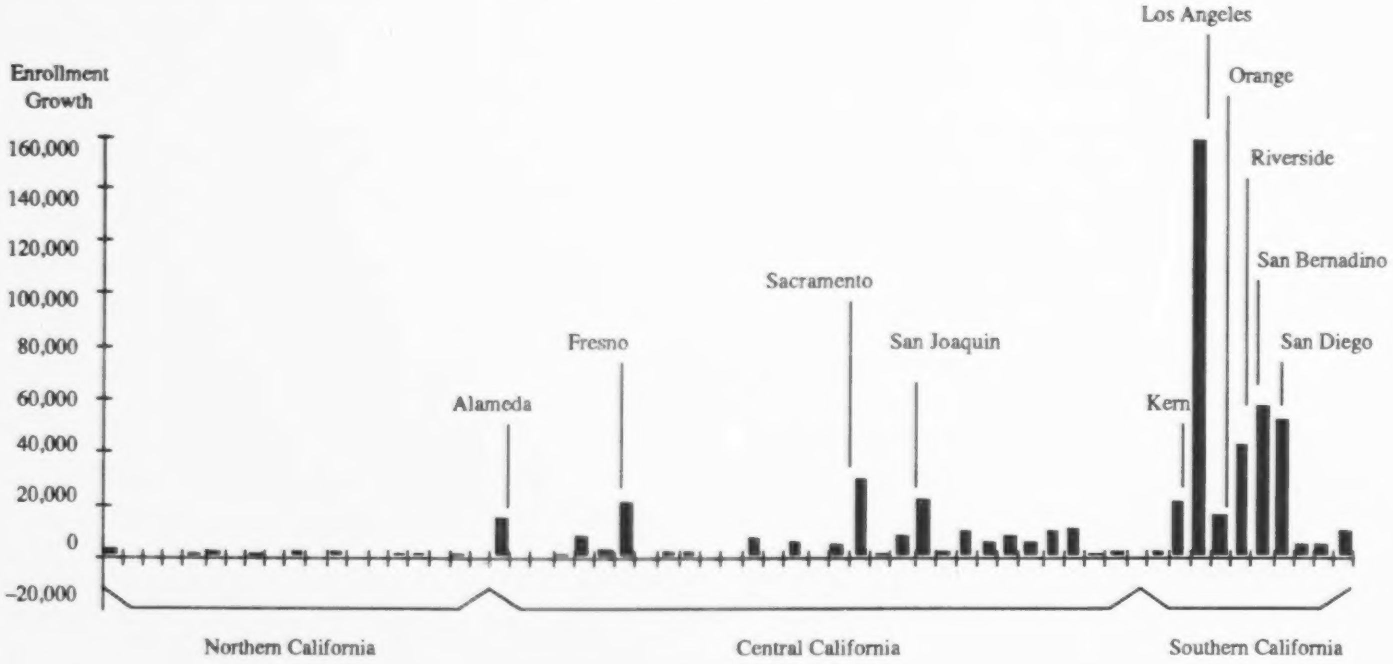
throughout the state. The overwhelming majority of students attend school in southern California. This is also the area, along with the Central Valley, in which enrollment growth is occurring most intensely. Northern California, particularly the coastal areas, is less affected. The geographically skewed nature of enrollments can be illustrated by this statistic: more than 29 percent of all public school students are enrolled in one county, Los Angeles. Conversely, the twenty-eight lowest-enrollment counties in the state account for only 28 percent of public school students. In effect, each of these low-enrollment counties averages only 1 percent of the state's student population. Figure 6-2 displays the geographic distribution and projected growth, by county, of California's students.

Elementary-grade enrollments are expanding the most rapidly. Growth has not reached the secondary years, though it will begin to do so in dramatic fashion in the 1990s. These increases have significant implications for resource dimensions such as construction of new schools and classrooms, employment of additional teachers, and allocation of added levels of financial support. More will be said later regarding each of these topics.

Third, the Complexity

Pupils in California display far greater racial, ethnic, and linguistic diversity than is likely to be found in schools anywhere else in the United States. The current kaleidoscope of classroom color, culture, and language evolved slowly for almost a century following the discovery of gold and California's entry into the Union. During the nineteenth and first half of the twentieth centuries, children of Asian and Hispanic immigrants were enrolled in school, but they constituted a relatively low percentage of all students. Also, owing primarily to segregated residential patterns, minority individuals were not highly visible to the white majority. World War II migrations vastly expanded the proportion of black students in the California school population. However, it is in the decade from 1978 to the present that population diversity has become the keynote of California's public schools. White students are the new minority in California's schools.

FIGURE 6-2 Projected Enrollment Increases by County, North, Central, and Southern California, 1987–1992



Note: Northern California = counties of Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, and Yuba.

Central California = counties of Alameda, Alpine, Amador, Calaveras, Contra Costa, El Dorado, Fresno, Inyo, Kings, Madera, Marin, Mariposa, Merced, Mono, Monterey, Napa, Placer, Sacramento, San Benito, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Tuolomne, and Yolo.

Southern California = counties of Imperial, Kern, Los Angeles, Orange, Riverside, San Bernadino, San Diego, San Luis Obispo, Santa Barbara, and Ventura.

SOURCE: California Department of Finance.

In the late 1970s, southern California and the San Francisco Bay Area became entry points for millions of individuals attempting to escape political unrest and other distressing events in Latin America and Asia.[5] Consequently, classrooms began to reflect the cultural and racial heterogeneity of the larger California population. By 1988, approximately one out of every six California public school students had been born outside the United States.

Table 6-1 displays the categories that the State Department of Education uses to classify students by race and ethnicity. It can be seen here that, for the 1987–88 school year, white students comprised 50.1 percent of total kindergarten through twelfth-grade enrollments. In other words, for the state's schools as a whole, "minority" students almost constituted a majority. In fact they did represent a majority in the elementary grades, and if Hispanic and black students had not dropped out of high school disproportionately, minority students would have been a majority of all students beginning in the mid-1980s.

TABLE 6-1 California Public School Enrollments by Race/Ethnicity, 1987–88

	Number	Percentage of Total
American Indian/Alaskan Native	34,129	0.8%
Asian	326,666	7.3
Pacific Islander	22,531	0.5
Filipino	95,104	2.1
Hispanic	1,353,224	30.1
Black (not Hispanic)	409,401	9.1
White (not Hispanic)	2,247,703	50.1

SOURCE: California State Department of Education.

School and Classroom Segregation

Despite the heterogeneity of the statewide system, a high degree of racial and ethnic segregation persists at the school level. In 1984, the last year for which such a statistic is available, 1.4 million of the state's Hispanic, black, and Asian students attended schools in which "minorities" comprised 50 percent or more of the student body. An elementary student is likely to attend a class in which most of his or her peers are from a similar racial or ethnic group. This is particularly true for white students. Secondary students are more likely to attend school and take classes with counterparts from other races and cultures.

This social separation occurs because various population segments are not equally distributed throughout the state. So-called minority students in fact constitute a majority of enrollees in nine of the state's fifty-eight counties. Among these "minority" counties are prominent jurisdictions such as Los Angeles, San Francisco, Alameda, Monterey, and Fresno. The degree of racial and ethnic geographic concentration is reflected further in the following facts:

- California has fifty-eight counties. One county, Los Angeles, contains 29 percent of all California's public school students. However, 45 percent of all the state's black and Hispanic students and 33 percent of all Asian students reside there.
- In contrast, 18 percent of all Hispanic students are sparsely distributed across a total of forty-seven counties. In thirty-three other counties, black students comprise less than 2 percent of total school enrollments. In each of nineteen counties, Asian students comprise less than 1 percent of enrollments.

Speaking English: Language Minorities

Reflecting the diversity of California's student population, about one-quarter of enrolled public school students speak a language other than English. About half of these students are English-proficient and half are limited-English-proficient (LEP). Approximately 13 percent of students (600,000) were limited-English-proficient in 1987. The majority of these students– 67.6 percent– attended school in nine southern counties. Los Angeles County alone enrolled more than 240,000 LEP students, accounting for 46 percent of the statewide total. The vast majority of these students speak Spanish as their first language.

The number of LEP students in California's public schools has grown rapidly and steadily since the 1970s. The number has nearly tripled from about 230,000 in 1977 to approximately 600,000 in 1987. Although approximately 50,000 students become English-proficient each school year (or are reclassified as English-proficient), more than 70,000 LEP students enroll in kindergarten each year, and additional students are identified as limited-English-proficient in upper grades.

The number of LEP students will almost certainly continue to increase, at least over the next five to ten years, although the 1987 immigration law may substantially reduce the rate of growth. Predictions have been as high as 650,000 students by 1990 and almost 900,000 by the year 2000. Of course, these figures are determined to a large degree by immigration policies and practices. If immigration patterns change, LEP student populations may also change.

What Are California's Schools and Classrooms Like?

As might reasonably be suspected, California's schools and classrooms differ from region to region, district to district, and school to school. However, from the perspective of the majority of California's public school students, schools are large, classrooms are crowded, and the buildings themselves are badly in need of repair.

Schools

California has a total of 7,125 individual public schools. Forty-six hundred of these are elementary, and slightly more than 2,000 are secondary. The remainder are specialized schools, frequently operated by counties, for handicapped students. The grade-level structure of California's public schools is depicted in Figure 6-3.

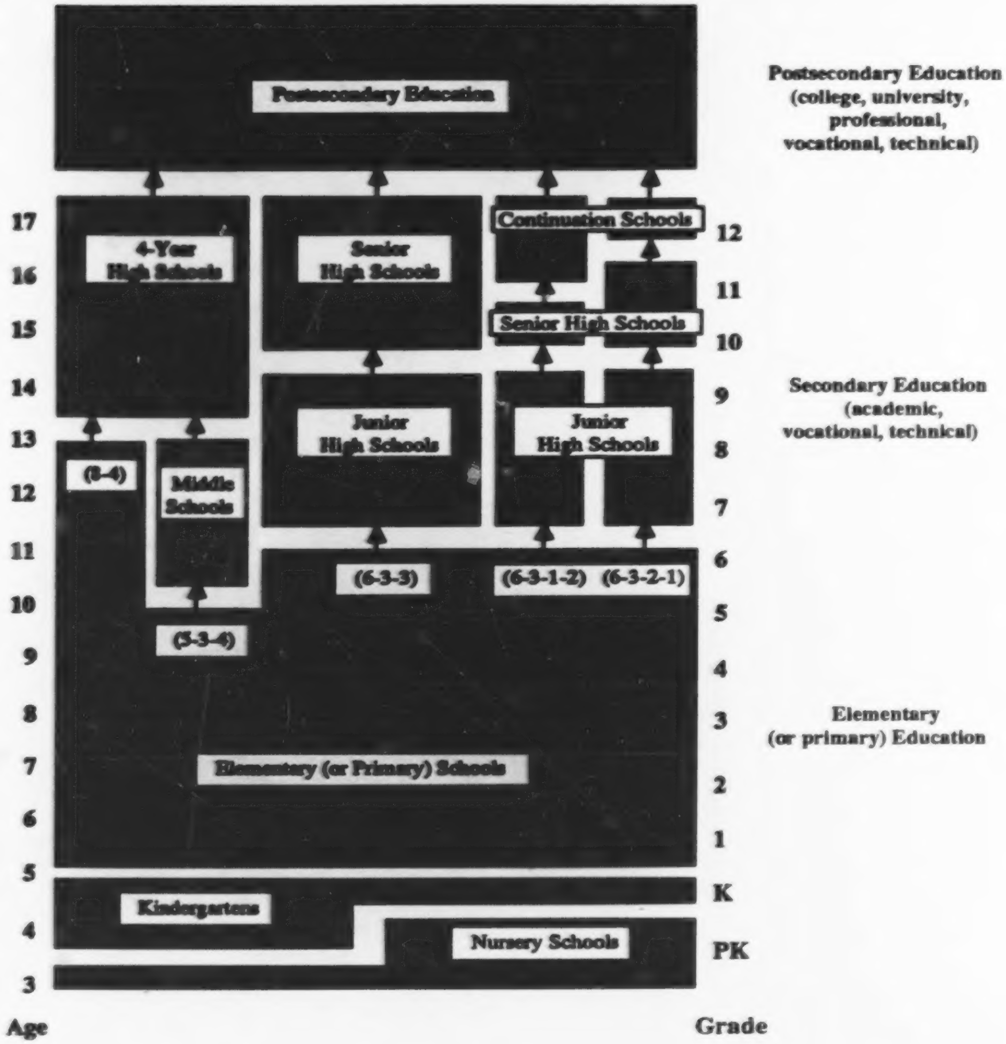
The average California child attends a large school, larger than is typical for the United States as a whole. For example, the modal elementary school in the state enrolls between 600 and 700 students. This school has three to four classrooms per level, kindergarten through sixth grade. The modal elementary student in the nation attends a school with fewer than 500 enrollees. This school generally has two classrooms per grade level.[6] There are upwards of 150 elementary schools in California with more than 1,000 students in them. Indeed, there are six elementary schools with 2,200 or more students. This is a staggering scale for this set of grades.[7] (Schools this size make it difficult to impossible for a single adult– the principal– to know the names of all the students.) Private elementary schools tend to be smaller than public schools. The mode nationally for private schools is fewer than 300 students.

Junior high schools and intermediate schools (encompassing grades 7–9 and 6–8) tend to be approximately the same size as elementary schools. The modal junior high and intermediate school also enrolls between 600 and 700 students. National data comparing secondary school size are not available. However, California's high schools tend to be particularly large. Almost 20 percent of high schools contain 2,200 or more students. (The state's diversity is evident here again: California has thirty-eight high schools with fewer than 100 students.)

Classrooms

California's individual classrooms, if anything, are even more crowded than its schools. A California child moving to New York or New Jersey would likely be entering a school with substantially smaller classes, with as many as a third fewer classmates.

FIGURE 6-3 The Structure of Education in California


Postsecondary Education
4-Year High Schools
Senior High Schools
Continuation Schools
Senior High Schools
Junior High Schools
Junior High Schools
(8-4)
Middle Schools
(6-3-3)
(6-3-1-2)
(6-3-2-1)
(5-3-4)
Elementary (or Primary) Schools
Kindergartens
Nursery Schools
17
16
15
14
13
12
11
10
9
8
7
6
5
4
3
Age
12
11
10
9
8
7
6
5
4
3
2
1
K
PK
Grade
Postsecondary Education (college, university, professional, vocational, technical)
Secondary Education (academic, vocational, technical)
Elementary (or primary) Education

Note: Adult education programs, while not separately delineated here, may provide instruction at the elementary, secondary, or higher education level.

SOURCE: Adapted from *Conditions of Education in the United States 1988,* (Washington, D.C.: United States Department of Education, National Center for Educational Statistics).

Class size is both a teaching and a learning condition. Teachers need classes that are sufficiently small to enable them to provide a measure of individual attention to each student. Students need the individual attention teachers can offer only in classes of manageable sizes.

According to a 1987 National Governors' Association report, California's "average" pupil-teacher ratio of 23:1 is the second highest in the nation (Utah's was the highest). Yet even the notion of "average" class size is a misleading one because it does not take into account necessarily small classes, such as those for handicapped and advanced placement students. Data recently analyzed by the California State Department of Education reveal that the ratio of students to teachers in California's K-12 regular education classrooms in 1985–86 was actually 28:1.

TABLE 6-2 Pupil-Teacher Ratios, in California, Five Other Large States, and the Nation, 1988

	Pupil-Teacher Ratios
CALIFORNIA	**23:1**
Illinois	17.2:1
Michigan	20.1:1
New York	14.8:1
Pennsylvania	16.2:1
Texas	17.3:1
National Average	17.4:1

SOURCE: American Federation of Teachers, 1988.

Another way to think about the number of teachers available per student is to calculate the *pupil-professional ratio*. In California in 1986–87 that ratio was 19.5:1, meaning that one certificated staff member was employed for every nineteen to twenty students in the state. The term "certificated staff" includes classroom teachers, support personnel such as bilingual and special education instructors who operate "pullout" programs (in which selected students are removed from their regular classroom for a portion of the day), pupil personnel staff such as counselors and psychologists, coordinators of categorical programs (in which funds are targeted to specific purposes), and school administrators.

Comparing the average pupil-teacher ratio of 23:1 to the pupil-professional ratio of 19.5:1 reveals that California has many certificated employees who are not in the classroom. Removing the 16,725 California school administrators from the certificated personnel category leaves a student-"teacher" ratio of 21:1, still reflecting a significant number of "teachers" who are not in the classroom. If these nonadministrative certificated employees who are currently out of the classroom assumed classroom duties, average class size in California could be reduced by 9 percent. If, in addition, some administrators assumed classroom responsibilities, class sizes could be reduced even further. These are significant findings because to reduce class size by employing additional classroom teachers costs $200 million for each reduction of one pupil per class.

The discussion of pupil-professional ratios is informed further by the previously mentioned State Department of Education (SDE) analysis of 1985–86 data. The department developed a composite portrait of an "average" California school. According to the SDE analysis, of the professional educators employed in the "average" California school in 1985–86, 70 percent were regular classroom teachers, 8 percent were special education teachers, 7 percent were pupil-support personnel (counselors, psychologists, nurses, and librarians), 7 percent were teacher specialists (subject area specialists or general curriculum specialists), and 7 percent were administrators.

The Physical Condition of Schools

Rapid enrollment growth, deferral of maintenance, funding shortages, and cumbersome state bureaucratic procedures have eroded the physical conditions of the schools attended by California's children. Since the 1978 enactment of Proposition 13, local school districts no longer have taxing and borrowing authority for purposes of school construction. The state is now almost totally responsible for approving and funding school facilities, their construction, and major repair. The backlog for California school construction, rehabilitation, and deferred maintenance totals $11 billion.[8]

Where once decisions regarding school facilities were made by school board members and school managers in hundreds of local school districts, the decisions are now highly centralized in a few state governmental agencies. The outcome has been a state agency logjam in the processing of local applications and a shortage of funds. From the time local school board members decide that their district needs a new school until such a building is approved and constructed may take as long as five or six years. Two of those years are filled simply with obtaining state agency "certification of need," approval of building plans, and financing.

According to state-provided information, approximately fifty California high schools currently are operated on so-called double sessions. These arrangements employ a shortened school day in order to use the facility as though it were two schools. Students attend in shifts, one early in the day, the other later. Such arrangements, while certainly to be preferred over no schooling at all, nevertheless severely curtail extracurricular activities and impose substantial wear and tear on students, faculty members, and the buildings themselves.

Previously mentioned enrollment increases suggest that an additional 23,381 classrooms will be needed by 1992 (15,466 for grades K-6, 5,025 for grades 7-8, and 2,890 for grades 9-12). The effort and expense involved in providing these facilities has provoked substantial local-level discussion about and enactment of state financial incentives for the use of school facilities year round. There are a variety of "year round" schooling plans that enable a particular building to be used by a third again as many students. The state's largest district, Los Angeles, has implemented a year-round plan for many of its crowded schools, but has so far resisted adopting the plan districtwide. The plan is controversial because it means altering the summer vacation traditions of some families.[9]

Who Teaches California's Children?

California's schools employ approximately 225,000 professional educators, of whom approximately 190,000 are classroom teachers. The remainder serve as administrators, guidance counselors, psychologists, and in a variety of other specialized capacities.

Overwhelmingly, schoolchildren are in contact with teachers. Elementary students are likely to be in the same classroom and with the same teacher most of every day. From time to time a "specialist" may come to their room, or students may move to another room for a short period for a special subject, such as music, physical education, or more intense instruction in reading or mathematics. In the sixth or seventh grade— sometimes even in the fifth grade— it is typical that students begin, for at least part of their day, to move from classroom to classroom for instruction in subject matter areas, such as English, science, and mathematics. Secondary students are also likely to encounter specialists, such as counselors and coaches, outside of a classroom context,.

The teacher that an average California elementary school student is likely to encounter will be a white 42-year-old woman, with a bachelor's degree from a California State University, and a master's degree in education, who has been teaching for fifteen years, and annually is paid slightly more than $31,000. This amount is higher than the national average for teachers, but it is not high compared to the salaries paid in other industrialized states such as New York or Michigan.(Table 6-3 and Figure 6-4.) Secondary school teachers are more evenly balanced between men and women.

Enrollment growth, plus increasing seniority among teachers in large cities, is creating a substantial demand for new teachers. Estimates suggest that California will need to hire approximately 15,000 teachers per year for the next decade. These numbers are placing a strain on conventional procedures for training and licensing teachers. Roughly one-fifth of all newly employed California teachers are not fully certificated by the state. They are hired with so-called emergency credentials. These shortages are particularly acute for teachers who instruct handicapped, non-English-speaking, and secondary school physical science students.

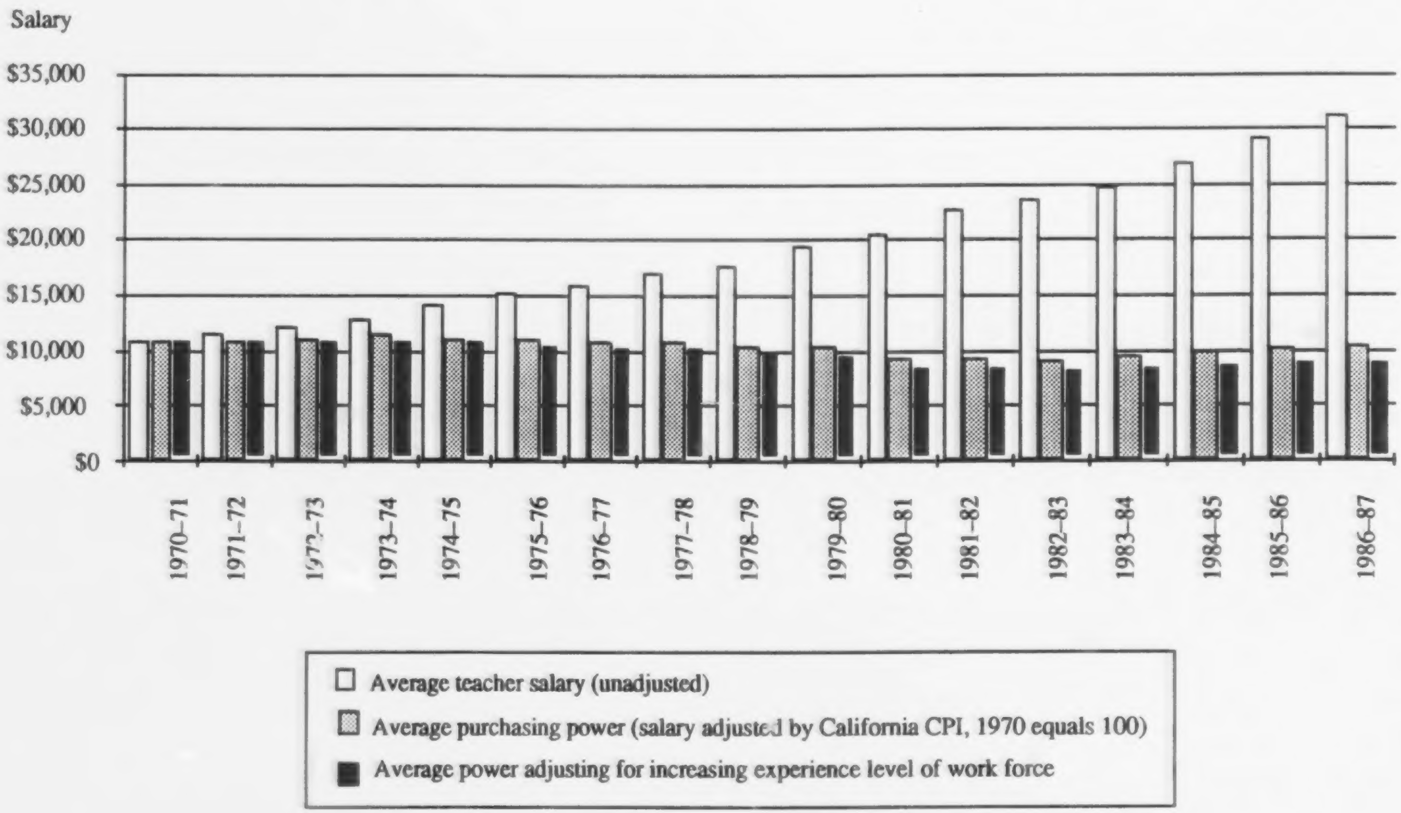
It is particularly difficult to recruit new minority-group teachers. California requires passage of a skills test to acquire a teaching credential (California Basic Education Skills Test, or CBEST). Figure 6-5 displays the difficulty that many minority teacher candidates have had in obtaining passing scores.

TABLE 6-3 Average Classroom Teacher Salaries, Selected States and Years (actual dollars)

	1969–70	1979–80	1982–83	1986–87
CALIFORNIA	**$10,324**	**$18,020**	**$24,035**	**$31,170**
Illinois	9,569	17,601	22,315	28,430
Michigan	9,823	19,285	26,556	31,500
New York	10,390	19,800	25,000	32,620
Pennsylvania	8,858	16,520	21,178	27,429
Texas	7,277	14,132	19,550	25,308
National average	8,635	15,966	20,715	26,704

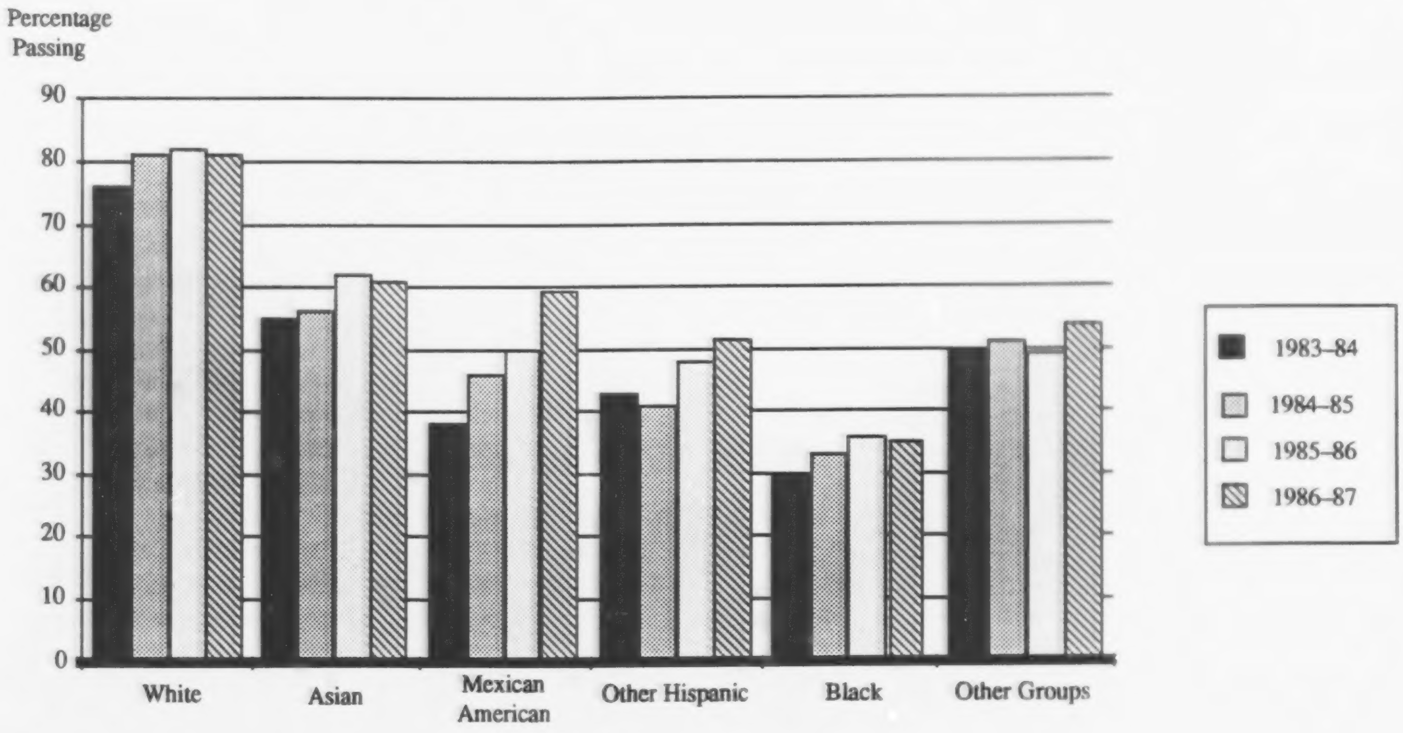
Note: Comparisons are made among large states with diversified economies and similar costs of living.
SOURCE: National Education Association, *Estimates of School Expenditures.*

FIGURE 6-4 Average California Teacher Salaries, 1970–1986, Adjusted for Inflation and for Increasing Experience Level of Work Force



SOURCE: Data from California Basic Educational Data System (CBEDS).

FIGURE 6-5 California Basic Educational Skills Test (CBEST) Passing Rates, by Ethnicity



SOURCE: Richard W. Watkins, "Fifth Year Passing Rates on the California Basic Educational Skills Test (CBEST) and Passing Rates by Institution Attended" (Sacramento: California Commission on Teacher Credentialing, September 1987).

What Is Taught and What Is Learned in School?

Elementary schools are expected to teach basic subjects and skills so that students can benefit from more specialized instruction in secondary schools. If judged by standardized test results, California's elementary schools are succeeding moderately well in meeting these expectations. At the secondary school level, however, student performance is below expectations.

Elementary School Performance

Whatever else they do, elementary schools are expected to teach reading, writing, and mathematics. California's schools teach these subjects and students regularly take state-administered (Comprehensive Assessment Program, or CAP) examinations that appraise performance on these three dimensions. Test results, particularly when viewed from a long-term perspective, are encouraging. In both the third and sixth grades, California students score higher than national averages in reading, written language, and mathematics.

Since 1980, third- and sixth-graders have been improving, and in 1986–87 third-grade students scored at the fifty-fifth percentile nationally in reading, the fifty-first percentile in written language, and the sixty-third percentile in mathematics. For the same year, sixth-graders performed slightly better in the first two areas and ranked at the sixty-sixth percentile in mathematics. For a school population as large and diverse as California's, this effort is commendable, and the fact that the test score trend is consistently upward is particularly encouraging.

Secondary School Performance

An eighth grade test was added to CAP in 1983–84. Since then, scores have increased 2 scale score points in reading, 13 points in written language, and 14 points in mathematics. Science, not added until 1985–86, has seen a 13-point increase in only two years.

Beginning in 1983, California substantially altered its high school graduation and university entrance requirements. As a consequence, students have begun to enroll in academically more rigorous courses. Table 6-4 illustrates the degree to which students have begun to enroll in intellectually more demanding subjects.

TABLE 6-4 Course Enrollments, Percent Change 1983–84 to 1987–88

Courses	Percentage of High School Students Enrolled 1987–88	Percent Change 1983–84 to 1987–88
Mathematics		
3 or more years	66.1%	[a]
Advanced mathematics	36.1	29%
English		
4 or more years	69.6	[a]
Science		
3 or more years	36.4	[a]
Chemistry	36.9	48
Physics	15.4	54
History or social science		
4 or more years	25.8	[a]
Foreign language		
3 or more years	22.3	[a]
Fine arts		
1 year art, music, drama or dance	52.5	[a]

[a] Data were collected differently in 1987–88 and therefore cannot be compared to 1983–84.

SOURCE: California State Department of Education, *Performance Report for California Schools 1988* and Policy Analysis for California Education (PACE) analyses of California State Department of Education data.

These higher requirements and enrollment shifts have not yet dramatically influenced the proportions of California secondary students eligible for entering the states' two major university systems, the University of California and the California State University. Course requirements to gain admission to the two institutions are substantially similar. Table 6-5 displays the percentage of graduates completing required courses (so-called a–f requirements). Two-thirds of the state's high schools report that only 30 percent of their graduates take the courses required for university admission. Only 8 percent of high schools reported that 50 percent or more of their students took the required courses. In 1984, only 28.2 percent of high school graduates had completed the a–f course requirements.

TABLE 6-5 The a–f Completion Rate, 1987–88

Rate of Completion[a]	Number of High Schools
< or = 10%	86
11–20%	214
21–30%	228
31–40%	125
41–50%	80
51–60%	24
61–70%	22
71–80%	6
> or = 81%	12

[a] Percent of high school graduates completing the a-f requirements.

SOURCE: California State Department of Education.

The weak academic nature of California's secondary schools is reflected in standardized test scores. The state's most able students appear to perform well compared to national norms. For example, the Scholastic Aptitude Test (SAT) is widely used to predict how well high school students will perform in college. The examination is not a particularly valid measure of what is taught in secondary schools. Nevertheless, it is widely relied on for evaluation purposes. When SAT results are compared, the percentage of seniors receiving good or excellent verbal scores is approximately 4 percent higher in California than in the nation. In mathematics, the percentage of California seniors receiving good or excellent scores is 11 percent higher than in the nation.

The College Board also offers the Advanced Placement Tests. These examinations assess the extent to which high school students have mastered college-level subject matter. In the time since 1983–84, California's high school seniors have been taking many more AP examinations (70,000 in 1987–88), and there has been a 92 percent increase in the number of seniors who have been passing them. The College Board reports that in 1988, 291,979 students in the nation took the AP examination. Of those, 67.3 percent received a score of 3 or higher, enabling them to accrue college credit.

Scores of average high school seniors taking the regular SAT are not as encouraging as for the outstanding students. Table 6-6 displays California SAT results, both verbal and mathematical, for sixteen years, from 1971–72 until 1987–88. Scores dropped systematically throughout the 1970s. Since 1980, SAT mathematics scores have been improving, and California now scores above the national average. Verbal scores have improved slightly since the 1982–1984 low point, and remain slightly below the national average.

TABLE 6-6 Scholastic Aptitude Test (SAT) Scores for California and the Nation, 1971–72 through 1986–87

	National		California	
	Verbal	Math	Verbal	Math
1971–72	452	484	464	493
1972–73	445	481	452	485
1973–74	444	480	450	484
1974–75	434	472	435	473
1975–76	431	472	430	470
1976–77	429	468	427	470
1977–78	429	468	427	466
1978–79	427	467	428	473
1979–80	424	466	424	472
1980–81	424	466	426	475
1981–82	426	467	425	474
1982–83	425	468	421	474
1983–84	426	471	421	476
1984–85	431	475	424	480
1985–86	431	475	423	481
1986–87	430	476	424	482
1987–88	428	476	424	484

SOURCE: College Board.

The SAT itself is an *aptitude*, not an *achievement* test. This means that it is designed to measure general abilities that are known to be related to academic success in the first year of college, rather than specific academic subject matter content. Although the abilities measured by the SAT are the result of students' total educational experiences—in school and out of school—ability tests are, for that reason, an imprecise measure of the subject area knowledge that comes more directly from instruction in the school curriculum. Such content knowledge is better indicated by the College Board Achievement Tests, which some colleges require for admission or placement. These "achievement" scores reflect the performance of a subportion of the already selected part of the student population who are college bound.

It is clear that California college-bound students are further below the national average in their knowledge of the broad span of academic content measured by the College Board Achievement Tests. Table 6-7 shows that the relative deficit of this group of California high school students compared to similar students throughout the nation has been increasing over the years, and the new scores for 1987 do not indicate that any reversal of this trend is at hand.

TABLE 6-7 College Board Achievement Tests, by Subject

	1983–84	1987–88	Percent Increase
Percent of California seniors scoring > or = 500			
American History	2.6%	3.1%	19.0%
Biology	1.3	1.6	23.0
Chemistry	1.0	1.4	40.0
English	6.3	7.9	25.0
Literature	0.8	1.6	100.0
Math Level 2	3.9	4.2	8.0
Percent of seniors in the nation scoring > or = 500			
American History	0.9%	1.2%	33.0%
Biology	1.1	1.2	9.0
Chemistry	1.1	1.1	0.0
English	3.9	4.6	18.0
Literature	0.4	0.6	50.0
Math Level 2	1.5	2.0	33.0

SOURCE: California State Department of Education.

In assessing the differences between California and the nation on both the SAT and the Achievement Test scores, keep in mind that the national average is constituted in a manner that puts California at a slight disadvantage. The national average is made up of the scores of students from all states, even though almost half the states are not "SAT states"; that is, these states predominantly use the American College Test (ACT) rather than the SAT, which in turn means that those taking the SAT from that set of states are usually a highly select group of students applying to highly selective out-of-state colleges. A fairer analysis would be to compare California with only the other SAT states. The data necessary to make this analysis are not available, but if such an analysis were made, it would probably bring California closer to the national verbal average and still further above it in math. The same effect would occur with the College Board Achievement scores; that is, the substantial disparities between California and the revised national averages would probably be somewhat reduced.

Looking only at the trend in California scores, it is also important to note that recent increases have been registered even though the proportion of high school graduates taking the SAT has increased substantially, a circumstance that (as noted) would by itself normally be expected to result in a decrease in the average score.

Ethnic Minorities

The California Assessment Program has not collected racial or ethnic data until recently. However, a recent review of CAP scores by ethnic group for the years and grades for which data are available (1981–1988) indicates that in all the subject-matter areas tested— reading, writing, math, spelling, history and social science, and science— students from all of California's ethnic minority groups have been raising their achievement scores.[10]

More important, these achievement gains appear to be increasing at a faster rate than those of white students. Table 6-8 presents data (again for the limited years available) on an Index of Minority Progress, which is a figure expressing minority scores as a percent of white scores. In all instances this figure is rising, indicating that while the gap between minority and white scores remains substantial— between 20 and 30 percent— that gap appears to be slowly closing. The largest gap exists for blacks and the smallest for Asians. Indeed, as has been generally observed and commented on, the achievement levels of Asian students in mathematics exceed that of white students.

Another interesting pattern in the data in Table 6-8 is the difference among the three ethnic groups in the relative standing of their eighth- and twelfth-graders. Among black and Hispanic students, twelfth-graders have closed more of the achievement gap between themselves and whites than have the eighth-graders. But among Asian students, it is the reverse. Eighth-grade Asian students have closed or nearly closed the gap in writing and reading (100.4 percent and 95.3 percent) and are well ahead of whites in math (109.0 percent), whereas, in contrast to the pattern among black and Hispanic students, Asian twelfth-graders have comparatively lower scores than eighth-graders (88.0 percent, 91.8 percent, and 103.1 percent).

A similar, though less marked, ethnic group pattern is present in the trend for SAT scores, where we also have data to compare California with the nation from 1984–1988 (Table 6-9). During this four-year period, SAT scores in California have closely mirrored those for the nation as a whole. The national and California scores were essentially identical in 1978, and both have risen about 1 percent since then. However, for both California and the nation, the scores for Hispanics and blacks have risen at a slightly greater rate than whites, while Asian scores, relative to whites, have remained about the same during this period.[11]

TABLE 6-8 Minority CAP Scores as a Percent of White Scores, as an Index of Minority Progress, Grades 8 and 12, 1984–85 through 1986–87

	Asians			Blacks			Hispanics		
	1984–85	1985–86	1986-87	1984–85	1985–86	1986-87	1984–85	1985–86	1986-87
Grade 12									
Reading		86.7	88.0		81.2	82.8		82.1	82.3
Writing		90.9	91.8		81.1	82.6		82.1	83.1
Math		103.3	103.1		79.7	80.2		83.4	84.6
Grade 8									
Reading		93.5	95.3	69.7	71.3	71.7	71.6	72.4	72.4
Writing		98.2	100.4	71.5	73.2	74.5	74.1	75.0	75.5
Math		108.5	109.0	68.0	68.8	69.4	73.4	73.8	73.6

SOURCE: California State Department of Education.

The educational and economic importance of maintaining this overall pattern of faster-than-average improvement for disadvantaged minorities is underscored by the fact that they constitute an increasing proportion of California's student and adult populations. Recent and projected changes indicate that between 1980 and 2000, the proportion of Asians in the grade 12 population will more than double, and the proportion of Hispanics will increase by nearly half.[12]

Staying in School: Appraising Children and School Performance

Nationally, the percentage of 25- to 29-year-olds who have completed high school has steadily been increasing:

- 1940– 38 percent
- 1966– 66 percent
- 1985– 86 percent.

Of young adults ages 18-24 living in the Southwest in 1984, the following percentages completed high school:

- 83 percent of whites
- 74.7 percent of blacks
- 60.1 percent of Hispanics.

The increase in the number of high school graduates has also led to an increase in those going to college. In 1940, only 6 percent of the nation's population were college graduates; by 1962, the number had increased to 13 percent; in 1986, 22.5 percent of the population had a college degree. Currently, almost five out of every ten 18- to 24-year-olds are enrolled in college.

Between 1976 and 1985, the number of black and Hispanic students graduating from high school steadily increased, but the number of blacks and Hispanics going on to college declined substantially. In 1976, fully a third of black high school graduates (33.5 percent) went on to college; in 1985 the number had declined to 26.1 percent. For Hispanics, a slightly greater decline occurred, dropping from 35.8 percent to 26.9 percent. These declines followed on the heels of a near doubling in the percentage of minorities in the nation's colleges and universities between the mid-1960s and mid-1970s. These declines occured at a time when minority achievement, as measured by test scores, was increasing.

Women, in contrast, have shown a steady increase as a percentage of college enrollment. In 1969, 43.4 percent of those entering college as first-time, full-time students were women; by 1985, women were a clear majority at 51.8 percent. These increases in college enrollment parallel the development of the women's movement that began during the late 1960s in the United States.

Although college enrollment declines have been predicted (because of declines in U.S. birthrates), there actually was a 7 percent increase in the number of students taking the SAT in 1986–87, an additional 130,000 students nationwide. Colleges also reported a surge in enrollments in the fall of 1987. In large part, the increased interest in higher education may have been a function of the widely recognized difference in income between college-educated people and those who did not graduate from college.

Dropping out of school is one of the best predictors of future poverty, in terms of employability as well as earning power. Of those 25 to 64 years of age in 1985, only 76 percent of the men and 44 percent of the women who had not graduated from high school were working, compared to 90 percent of the men and 63 percent of the women with high school diplomas. Men without high school degrees in 1983 earned three-quarters of what high school graduates earned, and approximately half of what college graduates earned.

Table 6-9 Scholastic Aptitude Test (SAT) Scores, by Race/Ethnicity, 1984 to 1988

	Number of Students Taking the Test		Percent Increase	Average Scores			
				Verbal		Mathematics	
	1984	1988		1984	1988	1984	1988
White	58,638	65,647	12%	450	453	493	501
Asian	13,235	21,026	59	382	390	506	509
Hispanic	7,339	10,016	36	373	377	419	424
Black	5,821	7,247	24	349	362	382	392
Native American	619	1,577	155	408	408	442	457
Total	102,348	119,784	17	421	424	476	484

Minorities are statistically more likely to be at risk than are white youth. Although this news may provoke some despair, it is important to maintain an historical perspective in viewing the situation of blacks. Between 1960 and 1970, for example, the black middle class doubled in size (a growth rate of 106.8 percent), and continued to grow, although at a slower rate, between 1970 and 1980 (61.9 percent). During the 1980s, partly because of the 1980-82 recession, the growth rate has declined, but it is still important to applaud the rather dramatic changes that have occurred.

Becoming pregnant and having a child as a teenager significantly increases a woman's risk of living in poverty. In a recent national study, only half the women who had become mothers before age 18 had completed high school at age 29, compared to 82 percent of those who bore their first child at age 18 or 19, and 96 percent of those who delayed childbearing until their twenties. Differences in college completion rates were even more dramatic, with less than 2 percent of teen mothers having college degrees, while almost a quarter of those who had delayed childbearing until age 25 or later had completed college degrees.

According to the Children's Defense Fund, in 1985 nearly three-quarters of all single-parent families with female heads younger that 25 years of age lived in poverty. These statistics are not easy to interpret because whatever causes lay behind teen pregnancy may also induce dropping out. Nevertheless, the high correlation between each level of education and adult distress justifies more research on the overall topic.

School Life

Children and youth spend more time in school than in any other single activity outside of the home. This has not always been the case: one need not go too far back into human history to find a time when only the children of the elite were educated, usually by tutors within a home setting. Even a half-century ago in this country, it was commonplace for children to receive no more than a sixth-grade education. Today, however, completing high school is judged to be the minimum requirement for adolescents, and completing college is increasingly viewed as the functional equivalent of the high school diploma of only a few years ago.

Not only do today's children spend a lot of time in school, but they also spend a lot of time at school engaged in before- and after-class extracurricular activities. There are no systematic data about these activities. However, they are generally voluntary, and the surmise is that children who engage in them probably enjoy the time.

Attitudes of Young People Regarding Their Schools

Children and youth are somewhat more positive in evaluating their school experience than are adults, although there are some significant differences among ethnic, racial, and economic groups. The 1987 Chicle Poll provides us with the most current pulse on national student attitudes.

Almost 80 percent of students polled report that they like school, while only 10 percent say the opposite. Among students in lower socioeconomic groups, the degree of satisfaction is slightly lower—but only slightly: 70 percent say they like school. Among black students, a lesser 66 percent express a high degree of satisfaction. Girls like school more than do boys. Of the girls, 83 percent express a high degree of satisfaction, compared to 71 percent of the boys. When students are asked to rate the quality of the particular schools they attend, more than 80 percent say they are satisfied, although fewer black students are satisfied (74 percent), just as are slightly fewer students in the lowest socioeconomic group (78 percent). Even among students who report that they dislike school in general, more than a majority (56 percent) say that they like the school they actually attend.

When U.S. students assign grades to their school, the results are more mixed. Somewhat more than half give their schools an "A" in providing safe campuses, teaching basic skills, and helping students to become good citizens. But fewer students think their schools do an excellent job in preparing them for college (47 percent), and only 41 percent think their schools do an excellent job in preparing them for work. The older the students, the less likely they are to assign high grades to their schools. Eight- to ten-year-olds, for example, give their schools an "A–" average, whereas 15- to 17-year-olds give their schools a "C+" average.

Sixty percent of students say that their schools should have more modern equipment; 47 percent say that their schools should pay more attention to the teaching of basic skills; and, perhaps most interestingly, 46 percent say that their parents should pay more attention to what is going on in the schools and to what students are learning.

Parental Involvement in Schools and with Children

The 1987 Metropolitan Life Survey, a national survey of parent and teacher attitudes, addressed the issue of parental involvement in children's education and documented the importance attributed by both parents and teachers to this interaction. Teachers were viewed by parents as being highly available (three-quarters of parents rate teachers excellent in this regard); yet teachers viewed parents as being much less available (on availability, 46 percent of parents were rated "fair" or "poor" by teachers). Their views were confirmed by the parents. When questioned about their actual participation in school activities, about a third of parents reported being actively involved with their child's school, a middle third were moderately involved, and a quarter to a third were very uninvolved.

Investing in Children's Schooling

On a per-child basis, California's investment in schooling is low. In 1987–88, the state spent less than the national average and less than every other major industrialized state, except Texas (Table 6-10). This low level of investment occurs despite the fact that California contains a disproportionate number of children whose social and linguistic backgrounds suggest that success in schooling will be difficult for them to attain.

One of the barriers to greater financial investment is the awesome number of children involved, and the huge amount of public money necessary to sustain current levels of effort, not to mention the amount it would cost to intensify the investment. Looked at in the aggregate, California's current investment in children's formal education is already enormous.

In the 1988–89 school year, total spending on kindergarten through twelfth grade will approximate $23 billion. This is by far the state's single largest budget item, and it greatly exceeds the total amount spent for education by any other state. Moreover,

TABLE 6-10 Comparison of Selected School Finance Variables, California Versus Five Other Large States

	California	Texas	New York	Illinois	Pennsylvania	Michigan	National
Average Daily Attendance (ADA) 1986–87	4,200,000	2,900,000	2,300,000	1,600,000	1,600,000	1,500,000	
Estimated expenditure per pupil ADA	$3,751	$3,584	$6,299	$3,980	$4,752	$3,954	$3,970
State and local expenditures for local public schools as percentage of total state and local expenditures 1985–86	20.8%	29.5%	21.8%	23.2%	26.8%	25.5%	24.0%
Estimated average classroom teacher salary 1986-87	$31,170	$25,308	$32,620	$28,430	$27,429	$31,500	$26,704
Student enrollment per classroom teacher salary 1986–87	22.9	17.5	14.7	18.0	16.4	20.9	17.8

Note: Comparisons are made among large states with diversified economies and similar costs of living.

SOURCE: National Education Association, *Estimates of School Expenditures, 1986–87*. U.S. Bureau of the Census, *Governmental Expenditures, 1985–86*.

projected enrollment growth, and even modest future levels of inflation, suggest that by 1997, school spending for the same level of service now offered will have to double over current levels.

An additional impediment to added levels of public investment in children is the interaction of a set of state constitutional amendments. In 1978 and again in 1979, the electorate enacted initiatives that limit local property tax rates and overall state spending levels. These two propositions— respectively, 13 and 9— severely curtail public spending at both the state and local level. Also, these are constitutional amendments, so they will take action by the electorate to be undone— improbable in the near future.

Where Does Schooling Money Come From?

Table 6-11 displays California school revenue by source for the period beginning in 1979. These data illustrate that state revenues constitute schooling's major support. (The state depends almost equally on personal income and sales taxes as its major sources of revenue.) Local property tax proceeds and federal contributions are smaller sources of support. Lottery proceeds, though highly visible to the public, are only a minor contribution (about 3 to 4 percent) to school spending. Voluntary gifts by individuals and organizations were over $1 billion in 1987–88, matching the contribution of the state's lottery to school revenues.

TABLE 6-11 Sources of K–12 Education Funding, 1979–80 to 1987–88 (in millions of dollars)

	Local*	State	Federal	Other	Lottery
1979–80	$ 2,180.0	$ 6,998.5	$ 1,109.4	$ 702.7	n.a.
1980–81	2,409.7	7,866.4	1,154.5	910.6	n.a.
1981–82	2,933.6	7,837.3	1,000.7	843.8	n.a.
1982–83	2,941.8	8,100.7	967.6	854.0	n.a.
1983–84	2,983.7	9,191.8	1,032.7	941.8	n.a.
1984–85	3,305.3	10,400.7	1,096.2	1,010.9	n.a.
1985–86 (estimated)	3,586.0	11,607.4	1,115.8	1,084.1	$ 558.3
1986-87 (estimated)	3,813.3	12,685.5	1,262.9	1,162.6	394.6
1987-88 (approximated)	4,088.3	13,076.1	1,225.1	1,246.8	493.0

* Includes state property tax subventions.

SOURCE: Legislative Analyst, September 1987, revised figures.

What Table 6-11 does not show is that even though California relies to a degree on local property tax revenues, these taxes are not at the discretion of local school boards, as in most states. Rather, state officials establish a per-pupil spending level, and then state and local funds are combined to make up that total. Increases in local property assessed value cannot, under California's constitution, accrue to the revenue benefit of local school districts. As noted earlier, even if a local school district chooses to increase its investment in children, it cannot rely on its tax base to do so.

Where Does the Money Go?

Ever since a crucial 1976 state supreme court decision,[13] California has been distributing school funds in a manner far more equal than most states. In subsequent trials, the state's judicial system has found that the modest per-pupil spending differences that still exist are within a legally tolerable range. Therefore, most California school districts have approximately the same amount of state and local revenue per pupil. Federal and state special funds, intended to assist with the education of handicapped students and children from low-income households, are distributed on the basis of entitlements. Consequently, districts with disproportionate numbers of such students (generally city school districts) receive greater shares of federal funds.

How are school resources spent, once they reach the school district level? How much is actually spent at a school and how much supports other activities? Using 1985-86 data, the California State Department of Education recently undertook such an analysis.

Expenditures per school average $2,046,000. These can be divided into classroom expenditures, site-level expenditures, district and county administration, and the State Department of Education. Classroom expenditures account for 63 percent of total school operating expenditures. Within that category, salaries for classroom teachers constitute 45 percent of total school expenditures; specialized teachers in fields such as special education and music and art receive 5 percent; pupil support personnel including counselors, psychologists, nurses, and librarians get another 4 percent; and books, materials, and supplies account for the last 4 percent of classroom expenditures.

Site expenditures, other than classroom expenditures, constitute 31 percent of total school operating expenditures. Operations, maintenance, transportation, and food take 19 percent of this total figure; instructional support, including curriculum specialists and supervisors and media technicians, receives another 5 percent; and school site leadership (administration) gets the last 7 percent.

District and county administration takes 5.5 percent of total school expenditures, and the state Department of Education gets the remaining 0.5 percent. If site leadership is added to these administrative expenses, administration totals just 13 percent for each school on average; operations, maintenance, transportation, and food total 19 percent; and classroom expenditures, including pupil support personnel, total 68 percent.

It is not currently possible to compare these spending patterns either with California over time or with other states. So, it is difficult to comment about the correctness of these spending patterns. One dimension does seem slender, however—classroom supplies, including textbooks, average only $125 per pupil. This is about $0.70 a day for each student for all supplies and books. Such an amount may be inadequate.

Who Governs This System?

Children in California attend a crazy quilt of school types arrayed over a bewildering organizational landscape. Efforts by parents and citizens to influence school policy are impeded by this confusing and overcomplicated set of governmental arrangements.

If a student, or more likely a parent, wanted to inquire about or influence schooling matters, he or she would encounter a byzantine labyrinth of governmental arrangements. The state legislature and governor are ultimately responsible for public school policy. However, from this point on, the topic of education governance becomes exceedingly complicated.

Schools are located in geographically contiguous local governing units, called school districts. Each district is a specialized government, drawing its administrative authority to operate schools from the state. Each district has an elected citizen school board and a chief executive officer, a professional educator who serves as superintendent.

School districts are of three principal types, elementary, secondary, and unified. The first two labels correspond to the grade levels they encompass; the third category encompasses K-12 schools. Sometimes local school districts coincide with municipal boundaries. Equally often they do not, cutting across city lines or encompassing more than one municipality.

California has 1,025 local school districts, a number reduced four- or fivefold from a high point over fifty years ago. These districts encompass an awesome range of rural to urban and rich to poor diversity. At one extreme is the Los Angeles Unified School District, the nation's second largest, with more than 600,000 students. At the opposite end of the continuum are a few small single-school, perhaps one-room, elementary districts, some of which are frequently in danger of having more school board members than students.

There are 635 elementary and 112 high school districts. Most of these are quite small in terms of pupil enrollments, though they may encompass thousands of square miles geographically. The overwhelming proportion of the state's students attend school in unified districts, of which there are 112.[14] There also exist county offices of education, responsible on several administrative dimensions for the districts and schools within their boundaries. Each county has an elected board of education and either an elected or appointed county superintendent. These officials have only limited statutory authority over local school boards.

The possible conflict at the county level between an elected board of education and an elected chief executive officer, however dismaying to those who would wish government to be rational, is not without higher-level precedent. The entire California school governance system nests within a state legal framework wherein the governor appoints a state board of education, which then has as its chief executive a superintendent of public instruction, who is a constitutional officer, like the governor, elected from a statewide constituency. This state and county apparatus then makes policy or administratively oversees elected district school boards and their appointed chief executives, local school superintendents.

Conclusion

California's education system is like no other in the nation in terms of its size, diversity, and governmental complexity. However, it currently is not well positioned to meet future challenges. The state's investment in schooling is relatively low. The need for reform is high.

Chapter 7

How Children Spend Their Time and How Community Factors Affect Their Well-Being

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The first chapters of this book sketch broad views of California's children and the major forces affecting their well-being, including family, school, and child care. Many other aspects of community also contribute to or detract from children's development and well-being. At the broadest level, for example, mass media wield a strong influence. Most children also participate in clubs, organized sports, and religious institutions. For many children, these activities constitute a major source of support and pleasure.

In this chapter we describe how everyday experiences affect children. We examine how children spend their time outside of school or child care. We explore the ways these activities influence children's development and what factors affect the type of activities in which children participate. We also present data on how the physical environment influences children's experiences.

Data Gaps

As earlier chapters indicate, available information on children in California often provides only a partial glimpse of their lives. This chapter is no exception. We have only limited data indicating how children decide to spend their time. Furthermore, much available data draw on national surveys and are not specific to California. At a few points, such as our brief discussion of television, the literature is extensive, but we can here only make a few generalizations and cite a few important studies.

In preparing this chapter, we have consulted a broad range of materials. First, we surveyed a variety of polls on attitudes of youth, the most valuable being the annual survey of high school seniors that has been performed since 1975 by the Survey Research Center at the University of Michigan (hereafter referred to as *Monitoring the Future*, the title of the multivolume series).[1] Second, of the analyses of how children spend time, one of the major studies is a study of 764 sixth-grade students from twenty different Oakland, California neighborhoods (hereafter referred to as "the Medrich study").[2] Third, we consulted a number of studies analyzing the behavior of children, many of which are based on children who do not live in California. These studies are cited when comparable California data are not available.

Finally, given the absence of data, we felt that the impressions and intuitions of people who work with young people were of value. We organized a series of roundtable discussions with California school counselors, parent educators, religious youth workers, and representatives from youth clubs and organizations. In addition, we conducted a limited number of interviews with representatives from youth organizations. The ideas and opinions of these individuals have significantly shaped the theoretical perspective of this chapter.

The greatest lack in our research is conversations with young people themselves. We did, however, organize several "focus groups" with teenagers, which proved extremely valuable.

How Children Spend Their Time

The aggregate and summary statistics that follow provide a very broad overview of how children spend their time. These analyses and comparisons are useful in establishing baselines of information for policymakers, but can only present in the most general terms the experiences of children in California today. There is no "average" child. Rather, the experiences of each child are local and particular. The world of a child is bounded by culture and time, by physical space and transportation, and by networks of family, peers, and formal organizations. Statewide averages and single-site case studies fail to capture the striking differences across types of communities and variation within communities and counties.

Two studies are particularly useful in providing an overview of how children spend their time. This study, by researchers at the University of Michigan's Institute for Social Research, is based on a national sample of 922 households that were surveyed in 1981.[3] Data on how children between ages 3 and 17 spent time were collected in the form of 24-hour "diaries" of activities during the previous day.

Tables 7-1 and 7-2 present the average time spent on eighteen major activities (on both weekdays and weekends), contrasting the time use of boys and girls, as well as the activities of children 3 to 11 years of age and young people 12 to 17. Not surprisingly, for both boys and girls of all ages, over half of their time on weekdays was spent sleeping and attending school. For younger children, the major activities were playing or watching television, which consumed over four hours per day. Teenagers also spent an average of two hours per day watching television, with sports and personal care consuming much of the boys' remaining time. For girls, these adolescent years see a shift from time engaged in play to household-oriented activities (housework and conversations) and to personal care. On the weekends, both children and young people spend more time sleeping, helping around the house, visiting friends, attending church, and watching television.

TABLE 7-1 Mean Time Spent in Major Activities by Age and Sex, Weekdays

	Age 3–11		Age 12–17	
	Boys (N=118)	Girls (N=111)	Boys (N=77)	Girls (N=83)
	Hours:Minutes	Hours:Minutes	Hours:Minutes	Hours:Minutes
Market work	0:16	0:00	0:23	0:21
Household work	0:17	0:21	0:16	0:40
Personal care	0:43	0:44	0:48	1:11
Eating	1:21	1:18	1:13	1:05
Sleeping	9:44	9:50	8:24	7:58
School	4:12	4:19	5:14	5:42
Studying	0:14	0:19	0:29	0:37
Church	0:07	0:04	0:03	0:07
Visiting	0:16	0:09	0:17	0:25
Sports	0:25	0:12	0:52	0:37
Outdoors	0:10	0:07	0:10	0:10
Hobbies	0:03	0:01	0:07	0:04
Art activites	0:04	0:04	0:12	0:06
Playing & games	2:17	1:55	0:37	0:13
TV	1:57	2:08	2:23	1:48
Reading	0:09	0:07	0:10	0:13
Household conversations	0:10	0:11	0:21	0:30
Other passive leisure	0:09	0:14	0:21	0:14
Other	0:22	0:25	0:14	0:17
Percent of time accounted for by above activies	93.9%	92.2%	93.1%	91.9%

TABLE 7-2 Mean Time Spent in Major Activities by Age and Sex, Weekends

	Age 3–11		Age 12–17	
	Boys (N=118)	Girls (N=111)	Boys (N=77)	Girls (N=83)
	Hours:Minutes	Hours:Minutes	Hours:Minutes	Hours:Minutes
Market work	0:07	0:04	0:58	0:25
Household work	0:32	0:43	0:46	1:29
Personal care	0:42	0:50	0:35	1:16
Eating	1:18	1:24	0:58	1:15
Sleeping	10:25	10:19	9:10	10:12
School	—	—	—	—
Studying	0:04	0:09	0:25	0:25
Church	0:53	1:01	0:40	0:36
Visiting	0:23	0:37	0:46	0:53
Sports	0:33	0:23	1:05	0:26
Outdoors	0:30	0:23	0:36	0:19
Hobbies	0:03	0:04	0:04	0:07
Art activites	0:04	0:04	0:11	0:09
Playing & games	2:57	2:46	0:35	0:24
TV	3:01	2:02	3:07	2:20
Reading	0:12	0:10	0:12	0:19
Household conversations	0:14	0:09	0:24	0:30
Other passive leisure	0:16	0:17	0:43	0:33
Other	0:20	0:29	0:10	0:04
Percent of time accounted for by above activies	92.7%	89.3%	88.4%	89.0%

The Impact of Neighborhood

Although descriptions of the time use of the typical or "average" child are informative, they are meaningless without environmental context. Unlike more mobile adults, children are severely constrained in the physical environment they experience. Their neighborhood represents more than an address; it is their social universe. Their friends and teammates, local playgrounds and libraries—all products of children's physical environment—necessarily shape their social worlds and the way they spend their time. Thus, this dynamic intersection of physical space and social experiences represents a crucial dimension shaping the condition of children's lives.

The three following examples of neighborhoods are intended to capture the variety of physical environments that delimit a child's experiences. The examples are taken from the Medrich study, and are based on the descriptions of children living in each of the Oakland neighborhoods.

Mountainside. You do not see children when you drive the hilly streets of Hillview. There are no sidewalks. Many houses are set back from the road, their windows turned to catch a view of the bay. There is something rural about Mountainside, a feeling of isolation, a sense that residents want to be left alone, and these hills provide them with privacy.

The shops, gas stations, and library are clustered in "the village" at the base of the hill. Here, adjacent to the school, is a landscaped park and recreation center where year-round programs attract children and adults alike.

It is not easy for children to get around in this neighborhood. Many of the hills are too steep for bicycles and skateboards. Children have to walk most places or be driven. Little public transportation is available. Consequently, children tend to spend much of their free time close to home. They play baseball and soccer in diamonds they have painted on the streets. They build tree houses and rope swings and share them with children who live nearby.

The only public building in the residential area itself is the fire station, a focal point where children gather for spontaneous games of softball. If their families are members, children have access to the tennis clubs, the swimming and cabana club, and the riding stables, but they usually have to ride up to them with their parents because there is no other way to get there. The recreation center at the bottom of the hill, run by the city's Parks and Recreation Department, is something like those clubs. It has fine facilities and offers a variety of things for children to do– tennis, art, and dancing classes. Many children are avid participants, probably because there is so little public play space in the hills. As a result, the center is one of the most successful in the city.

Rosewood. In the Rosewood area, each house is surrounded by its own lush shrubbery. Few houses have fences. They merge yard on yard into one lavish slope of greenery. The sidewalks mark the only boundaries. Children ride their bicycles along them and play softball in the connecting streets.

The area's only public space is a city block that houses the elementary school and its playground. Children walk up here often in summer. They sometimes check out sports equipment at the playground but leave before the older kids "take over." Then they congregate in rugged places, abandoned lots that are mostly inaccessible to adults.

The neighborhood, which is centered on the school, works well for children. Since there are many young families on every block, Rosewood is dense with children. Finding friends poses no problem.

Glenn. Glenn begins abruptly beyond the block of trucking companies and shipping warehouses that crowd the freeway exit. Where the billboards and storefronts stop, flowers, sparsely planted, spring up along the sidewalks. The houses look like fortresses. Most are brashly painted in colors that accentuate their imposing characters. In other parts of the neighborhood, the houses are smaller, blander, hidden among each other. In this area, apartments are more common. Neighbors sit on bannisters. There are many more people on the streets and more children hanging around than in other areas.

Although buses and large trucks run through continually, there are no stop signs, even on the most heavily traveled streets and alleys. Shops and churches are located mostly in one area. The triangular stores on the corners create a sociable atmosphere. On one block there are three churches.

At the top of the hill stands the junior high school. Most of Glenn's sixth-graders will be enrolled there somewhat reluctantly. It has a forbidding appearance. There is no grass anywhere in sight. The gates are locked and the windows boarded up during the summer. Vandalism rates are very high.

Glenn Park, near the elementary school, is an oasis in the middle of the neighborhood. The park is a long hill of grass that slopes into the street below. The recreation center at the top and the tennis courts appear popular. Even late on a workday morning many parents are there with children.

Play space is a problem, especially because many children, boys and girls alike, enjoy team sports. Often they play in vacant lots and side streets, some strewn with old tires, paper, and glass.

Children in the Glenn neighborhood are rarely alone during the day. They go into each other's houses and around the neighborhood in loosely knit groups. They are always on the move.

Variables Affecting Time Use

As the above three vignettes illustrate, the factors that shape children's activities are multiple and complex. Obviously, parents influence a child's activities at all ages—much more totally for young children than for teenagers. Apart from parental involvement, a child's experience is greatly influenced by the *availability* and the *quality* of the activities offered. Where children live—in an urban or rural setting, an inner-city apartment or suburban home—affects their access to public facilities, how safe it is to play on the streets, and whether there are parks, libraries, beaches, or mountains to enjoy.

In addition to physical space, children's activities vary to a large degree, dependent on a number of social and economic factors. Probably the most important are:

- *Social Class.* Family affluence determines the access a child has to music lessons, dance classes, travel, and a host of other experiences and opportunities, including the sports in which one participates as well as exposure to cultural events.
- *Family Status.* Whether a child comes from a single-parent family, has parents who are divorced, or lives in an institution or with foster parents has implications for whether he or she has responsibility to care for a younger sibling, spends summers or weekends at the divorced parent's house, or has a mother free after school to transport him or her from one lesson, class, or activity to another.
- *Parental Values.* The commitments and values of parents override many environmental and external factors, especially as expressed in whether children are taken to museums, art galleries, and concerts, how much television a child watches, whether he or she does homework, and whether parents make world events, religious issues, or politics into topics of family discussion and involvement.
- *Ethnicity.* Although generalizations can be made about how Asians, Hispanics, and blacks differ—especially in terms of differences of home life and immigration history and experience—it is equally important to acknowledge that ethnicity must always be qualified in terms of social class. Middle-class blacks, for example, differ very little from middle-class whites.
- *Physical Health.* How children spend their time depends considerably on whether a child has a physical handicap, is plagued by allergies, or possesses good health and excellent physical coordination; genetic predisposition and early childhood (including prenatal) intervention play a significant role in the later life experience of children.
- *Personal Values.* Whatever influences may surround a child, there is an important role for personal initiative, individual choice, and heroic commitment; reality is a matter of a child's interpretation just as it is conditioned by external factors of family and social experience.

In the following sections, we describe more fully the limited data on the range of activities available to children, their accessibility, and their content. Aside from television, most activities are generally provided by local government and the voluntary sector. To some degree, this results in a mix of activities that reflects the interests of the neighborhood children and the values of their families. At the same time, this reliance on local control and voluntary resources may increase the disparity in available activities across neighborhoods, cities, and counties. In particular, children from low-income areas may lack the quantity and quality of programs and facilities available to children from affluent families.

Youth Clubs and Organizations

Youth organizations have historically played an important role in the lives of many children. To the extent that children participate in such activities voluntarily, they provide a source of enjoyment to children. Youth organizations may also provide adult role models to children, offer a peer group for friendships, and allow for important skills training, as well as give children access to a network of support systems.

Given changes in family structure, the social role of youth organizations is increasing rather than declining. Many of the functions previously performed by the family—or the extended family of uncles, aunts, and grandparents—are now being assumed by the schools and various voluntary associations, such as youth clubs and organizations.

Membership Data

Nationally, there are more than 300 different youth associations in the United States, with 4-H being the largest, followed by the Boy Scouts of America, Girl Scouts, and Boys Clubs of America. Estimates regarding the percentage of young people who belong to youth organizations vary from one-third to one-fifth of all elementary and high-school-age youth. Older teenagers are typically less involved than younger children.

Although we have no reliable statewide data on how many children participate in youth organizations (some organizations only collect statistics by region or council), the data from the Medrich study provide a picture of one urban community in California. Medrich found that the average Oakland child participated in 2.6 organized activities, with involvement in various team and individual athletic pursuits ranked highest, followed by programs in the performing and creative arts, and then youth organizations. Ten percent of the children in this sample participated in boys' clubs, with slightly over 15 percent of males and females belonging to Boy Scouts and Girl Scouts.

There are differences between the children who belong to youth clubs and organizations and those who do not. The best available data come from a national survey of 58,000 high school sophomores and seniors conducted in 1980.[4] Approximately 20 percent of these teenagers indicated that they were part of youth organizations such as the Scouts and YMCA or YWCA. Although young people from all economic, racial, and ethnic groups belonged to such organizations, members tended to come from higher-income families. With regard to personal characteristics, members were more likely than nonmembers to report being in an academic program, to report that their usual grades were Bs or better (56.5 percent compared to 45.9 percent), to participate in extracurricular school activities, and to be strongly committed to the idea of going to college (74.3 percent compared to 59.4 percent).

Program Outreach

Youth organizations must be accessible to children. For the most part, this requires that meetings or facilities be located reasonably close to a child's home. Parents may not have the time, resources, or inclination to take children to distant locations. In addition, programs must be varied to reflect diverse interests of children from different cultural groups and, considering the large number of children from immigrant families, program staff in some areas should be bilingual.

We cannot tell how many organizations meet these needs. Many youth organizations are currently making a major effort to reach low-income and ethnically diverse populations, though there are only limited data on the extent to which they have succeeded. The Boys Clubs of America, for example, has intentionally located most of its centers in inner-city areas. Nationally, in 1986 the Boys Clubs of America served 1,285,000 youths, of whom two-thirds were from families with an annual income under $15,000. Fifty-one percent were from minority families, 47 percent were from single-parent families, and nearly one-third were from families receiving public assistance.

According to Club officials, there are two types of youth involved in the Boys Clubs of America. "Seasonal" youths join Boys Clubs for a specific activity, usually to participate in a sport such as basketball. "Regulars" regard the Boys Club as a second home; they are at the center five or six days a week, often starting immediately after school, and spend more time at the Boys Club than with their families. It is with these youth that the Boys Club often intervenes in significant ways.

In recent years, other organizations have been developing programs to meet the needs of working parents and to reach children in low-income areas. For example, the Boy Scouts and Girl Scouts have changed their program style by going to the school campus to offer "In-School Scouting," particularly in inner-city areas. Their intent is to offer after-school programs for children who might otherwise go home to an empty house. In Los Angeles, for example, the Boy Scouts have enrolled 6,000 inner-city kids in after-school Varsity Scouting programs, the majority of them Hispanic and black youths. Similarly, the Girl Scouts in Los Angeles rent sites in churches and other facilities, and girls can drop in between 3 and 5 P.M. on a regular or intermittent basis. They have established a Scouting program to serve girls in Year-Round Centers who are "off track" because they are enrolled in year-round schools. The Girl Scouts are also attempting to respond to the large Asian population in Los Angeles, about 65 percent of whom are foreign born. In addition to reaching out to new populations, many organizations have switched from single-sex to coed, to make them more attractive and to expand their reach.

Youth clubs and organizations appear to benefit children in many ways. In 1986, Louis Harris and Associates interviewed 1,200 alumni of the Boys Clubs of America. According to the Harris report, "More than nine out of ten alumni report that being in a Boys Club had a positive effect on their lives, on learning to be a leader, on getting along with others, and on success later in life." Over 75 percent of the respondents stated that "the Boys Club helped me to avoid trouble with the law." In explaining the value of their experience with the Boys Clubs of America, interviewees repeatedly cited the importance of Boys Club staff as role models and as "father figures."

Sports Programs

Many children spend a great deal of time involved in organized sports programs. In Medrich's study of Oakland sixth-graders, more than half of the children took part in at least one sports program (71 percent of the boys and 47 percent of the girls). In recent years, sports participation has become more available to girls. In 1966, men were three times more likely than women to earn a high school varsity letter. By 1985, two women for every three men had earned a varsity letter (54.2 percent of the men and 38.2 percent of the women).

Athletic and sports programs in which young people participate occur in a variety of settings, ranging from after-school sports programs to activities organized by YMCAs, Boys Clubs, and neighborhood recreation centers. In addition, there are national organizations such as Little League and the American Youth

TABLE 7-3 Youth Served by Selected American Organizations[a]

	Percent of Membership	1984 Membership	Percent Change Since 1978[b]
American Red Cross (1917 as Junior Red Cross)			
School students involved in services		2,453,504	n.a.
BigBig Brothers (1904)/Big Sisters (1908) of America (Merged 1977)		100,000	n.a.[c]
Boy Scouts of America (1910)		3,656,895	+11
Tiger Cubs (Age 7)	4%		
Cub Scouts (7–10)	41		
Scouts (11–17)	28		
Varsity Scouts (11–17)	1		
Explorers (15–20)	11		
Career Awareness	15		
Boys Clubs of America (1906)		1,275,000	+22[d]
Ages 6–7	10%		
8–10	29		
11–13	33		
14–18	29		
Camp Fire, Inc. (1910 as Camp Fire Girls)		337,000[e]	n.a.
4-H Program (1914)		4,422,932[f]	-16
Ages 9–11	61%		
12–14	27		
15–19	12		

[a] Figures are for 1984 unless otherwise noted (year of founding in parentheses).

[b] 1978 figures are from D. James, Description Study of Selected National Youth Serving Organizations, Washington, DC, U.S. Department of Agriculture, SEA-Extension, 1979.

[c] BB/BS not included in 1978 study; 1979 BB/BS Annual Report lists 100,000 youth served; 60% of current population served is male, 40% female.

[d] Membership figure includes 300,000 girls (24%); since 1978, males served increased 10%, females 45%.

TABLE 7-3 Continued

		Percent of Membership		1984 Membership	Percent Change Since 1978[b]
Girl Scouts of the USA (1912)[g]				2,172,000	−14
Daisies	(Age 5)	3%			
Brownies	(6–8)	52			
Juniors	(9–11)	34			
Cadettes	(12–14)	7			
Seniors	(14–17)	2			
Not in Troops		3			
Girls Clubs of America (1945)				200,000	−11
Age 6–18					
Junior Achievement (1919)				616,293	+107
Business Basics	(Grades 5–6)	16%			
Project Business	(8–9)	45			
Companies	(10–12)	34			
Applied Economics	(11–12)	4			
YMCA (1851)			Youth Served:	6,699,974[h]	+46
Age 1–5		17%	Members:	2,801,538	+ 9
6–11		59			
12–17		24			
YWCA (1855)			Youth Served:	203,098[i]	−37
Female members	(Ages 12–17)	55%	Members:	112,601	−47
Female nonmembers	(12–17)	27			
Male associates	(12–17)	18			

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[e] Unduplicated service figure, 1984 through August 1985.

[f] 54% of the membership is female; 46% male.

[g] Figures are for September 30, 1985; 1985 is first year of full implementation of Daisy Program.

[h] 47% of all youth served female; 45% of membership female. Among 12–17 year olds, 42% of the members are female; in the 12–17 age group, membership has declined by 19% since 1987, while there has been a 78% increase in the number of other registered participants in programs.

[i] Figures are for 1982.

Soccer Organization (AYSO), which are very prominent in California. For example, in 1986, 230,000 youth (between the ages of 6-18) participated in Little League baseball on 17,400 teams; 143,969 California youth were registered in AYSO soccer programs in 1987, with most of these youth being from Southern California (122,622).

There are no data on how children and others perceive organized sports. Their active participation would indicate that they, or their parents, value participation. These activities may relieve boredom, provide a sense of accomplishment, and build independence. Organizations such as Little League and AYSO also stress that these activities teach sportsmanship and build moral character. However, critics of organized athletic programs for children and youth claim that the noble aspirations announced in the literature of these organizations is often not experienced on the playing field. Competitive parents who have "professional" expectations for their children obviously detract from the fun and sportsmanship that coincide with the stated goals of organized sports for children. Likewise, the attitude of the parent coach is extremely important in terms of the values (as opposed to the physical skills) that are learned.

Like other recreation activities, organized sports programs require physical facilities to support particular athletic endeavors. And like recreational facilities generally, these are not equally distributed in all communities, nor is what exists always entirely appropriate to changes in the ethnic population. For example, parts of Los Angeles County with a large Hispanic populations have a surplus of baseball diamonds but an absence of soccer fields, with intense competition for the few fields that exist.

Given the amount of time children spend in recreational and sports activities, it is particularly disturbing that we know so little about the availability and accessibility of these activities for most children or about the impact of participation on children.

Parks

Parks and recreation departments are a ubiquitous feature of most municipal governments, providing services that range from public zoos and wilderness areas to local neighborhood miniparks, from extensive athletic facilities to staffed summer recreation programs. Children and youth are active users of such facilities.

There are no statewide data indicating the availability of parks to children. At least in some urban areas, many facilities seem to be available to children and their families. For example, in 1983 the Los Angeles municipal parks and recreation facilities included over 150 recreation centers and 300 park sites under its jurisdiction, ranging from the 4,107 acres of Griffith Park to neighborhood miniparks. In San Francisco, 65 centers and 200 staffed playgrounds provide a variety of athletic and aquatic programs, cultural activities, and community services.

Unfortunately, we lack data on use of these facilities. We cannot determine whether use varies by age, gender, race or income level. Some evidence, however, suggests that these facilities are not equally available to children. A study conducted by the Coleman Advocates for Youth compiled a recreation availability index for all neighborhoods in San Francisco.[5] The study showed wide variations stretching across the city, with availability roughly corresponding to income levels and property values. Medrich found similar disparities within the city of Oakland.

The majority of San Francisco's children do not participate in structured, supervised after-school activities—less than one-fifth of children ages 5 to 14, and less than one-third of children ages 5 to 9, participate in some program after school, according to the Coleman group. The accessibility of recreation facilities and programs, rather than the availability or the nature of the programs, appears to be the primary reason for such low use. Parents hesitate to send their children to recreation areas that are unsupervised or located in an area considered unsafe.

Libraries

The public library can be an important part of a child's social and educational experience. Libraries are often places where children *choose* to go. They are commonly facilities within a child's zone of mobility, reachable on foot, bicycle, or skateboard. In suburban and rural areas, usage patterns may be mediated by the child's dependency on transportation provided by adults.

There are no statewide data on library usage. Based on national studies, we estimate that over half of all library use is by or on behalf of children. However, the Medrich study found that only 14 percent of the children surveyed visited the library once a week, and 25 percent visited more than once a month.

A crucial issue in library usage is the access and availability of library resources for children. California has over 2,900 library service outlets, about a third of which are building sites, and the rest bookmobile stops. But as with parks, the neighborhood surrounding the library facility is an important factor in usage. Beyond this consideration, the degree to which libraries emphasize special children's programs or resources will also affect use rates.

Librarians report a cluster of factors have altered children's library programs over the past decade. For example, the dramatic changes in the child population—increasing racial, ethnic, and linguistic diversity—have several implications for libraries, the services they offer, and the children who use them. Patterns of collection in children's materials have shifted: the San Francisco Public Library's children's services division now collects children's books and materials in 37 different languages. In addition, many immigrant students are unfamiliar with libraries, indicating a need for community-wide information on library resources and policies. Automation and computerization in library processing presents challenges for both librarians and the children using the services. Finally, librarians throughout California report the use of libraries as de facto child care services for children who arrive after school and stay until closing or when their parents arrive.

Religion

Religious institutions play a major role in the lives of many children. Because religious experience takes so many forms, we cannot explore all the ways in which California children's lives are affected by religion. We can present data on reported attendance at religious services, and, for older children, their reports on the importance of religion to their own well-being.

Religious institutions are important to about half of America's youth and children. The rest seldom attend, except for occasional ritual events such as weddings, funerals, or major holy days of their particular faith. Religious activity of young children, as one might expect, directly reflects their parents' involvement with religion; but interestingly, teenagers also parallel parental attitudes and practice.

When asked about the importance of religion in their lives, in 1986, slightly more than half (53.2 percent) of high school seniors living in the western United States said that religion is either "pretty important" (29.4 percent) or "very important" (23.8 percent). Of these seniors, 14.4 percent reported that they attend religious services once or twice a month, and 31.9 percent say they go to religious services once a week or more often.

According to a Gallup Poll, approximately 20 percent of America's teenagers consider themselves to be an evangelical—that is, one who is "born again," has tried to encourage someone to accept Jesus Christ as his or her savior, and holds a literal view of the Bible or believes the Bible is not mistaken in its statements and teachings. Fifteen percent of teenagers in the western United States say that they read the Bible daily. Both the Young Life and Youth for Christ evangelical organizations are active on many high school campuses.

There are significant differences among different groups with regard to attendance at religious services. For example, black youth consistently show more regard for religion than do white youth. Nationally, 51.3 percent of black seniors say that religion is "very important," compared to 22.5 percent of whites who feel that way. Black youth also attend church more frequently than whites. Nearly 60 percent attend more than once a month, compared to 50.7 percent of whites.

Changes in Youth Religiosity

Between 1976 and 1986, there have been modest declines in both religious practice and attitudes of high school seniors in the western United States. In 1976, 37.1 percent attended religious services weekly or more often, compared to 31.9 percent in 1986. Similarly, there was a slight decline in the number who said that religion was "very important" in their life (27 percent in 1976, compared to 23.8 percent in 1986). Also, there was an increase in the number of seniors saying there is dishonesty and immorality in the leadership of churches and religious organizations (9.1 percent in 1976, compared to 13.7 percent in 1986).

Impact on Well-Being

Given the diversity of religious practice in the United States, it is difficult to generalize about the effect that religion has on youth. Like other organizations, religious institutions may provide youth with a community of friends, a support network of both peers and adults. And because religious institutions are voluntary associations, they can provide opportunities for youth to exercise leadership as well as creative initiative in designing programs and structuring community.

Based on discussions with church and temple youth leaders, it is apparent that religious groups serve different needs of different populations of children. For example, youth leaders serving white suburban teenagers said that one of their tasks is to help young people deal with the pressures to achieve being placed on them by parents. The church is a respite from school and parental demands. In contrast, youth leaders serving black, inner-city youth said that one of their goals is to increase pressure on their young people to achieve, holding up models of academic and financial success.

Religion seems to have different social functions in different communities. Religious youth leaders from the suburbs view themselves as competing for the allegiance of young people who have other attractions, agencies, and alternatives available to them. In contrast, some youth leaders working in less-affluent neighborhoods seem to feel that participation in church activities is, for many inner-city youth, an alternative to gang activity and street violence. The church represents a "counterculture"—a symbol and expression of an alternative way of life.

Media and Music

Television

In the last forty years, few things have more affected the way children and youth spend their time than the introduction of television into the American home. However significant family or school may be in the lives of children, youth spend more time watching television than engaging in almost any other activity.

In 1947 there were only 14,000 television sets in the United States; 0.04 percent of all homes had a set. By 1950, 9 percent of the homes had televisions (3.8 million). Today, 98 percent of all homes have television sets, many of them with accompanying video players. Three-quarters of 11- and 12-year-olds live in a home with more than one television; almost half of these children report having a television in their own bedroom at least some of the time.

Between the ages of 6 and 18, children watch on average 16,000 hours of television compared to only 11,000 hours spent in school.

Who Watches Television? Table 7-4 shows the differences in television viewing for California's children by grade level as well as year. Although the "average" amount of time children spend watching television is quite well known, perhaps more interesting is the wide range in the amount of time different children watch television. National data for high school seniors show significant differences in the amount of television that they watch, ranging from 18.2 percent who said that they watch a half-hour or less per day, to 16.7 percent who said that they watch 4 hours or more. A majority of seniors watch between 1 and 3 hours each weekday. However, seniors who plan on attending a four-year college were less likely to be heavy television viewers.

A number of studies have shown that black children watch considerably more television than do white children. In Medrich's study of Oakland sixth-graders, parents were asked to rate their children's television-viewing behavior. The effects of ethnicity were much more notable than family income, with twice as many black children as white children being described by their parents as "heavy viewers." For white children, the number of children who were described as light television viewers increased substantially as the educational level of the mothers increased; this relationship was not true for black children.

The same differences in television-viewing behavior appear to exist between black and white youth who are older: 34.8 percent of black high school seniors in 1986 said that they watched 5 or more hours of television on a typical weekday; in contrast, only 8.1 percent of white seniors made the same statement.

Impact of Television. There is substantial controversy over the impact of television on the well-being of children. From a child's perspective, television appears to be a source of pleasure, although sometimes the child watches out of boredom or in a casual manner while engaging in other activities, such as homework, play, and so on. Television viewing is also a major way families spend time together and studies have found that such viewing can promote family cohesion, as well as be informative and educational.

Still, there is significant reason for concern regarding the amount of time some youth spend watching television and the influence of television both on *what* children think as well as *how* they think. Successive surgeons general of the United States have been among the most outspoken critics of the influence of television on children. In 1982, the surgeon general reported that violence on television leads to aggressive behavior of children and teenagers. The report concluded:

> Although there is some evidence that young children's imaginativeness and the stories they use in spontaneous play are enhanced by television materials, the predominant evidence suggests that heavy viewing is associated with lower imagination and less creativity. There is reason to believe, moreover, that under conditions of unsupervised heavy viewing, children may not learn the necessary distinctions between "realism" and "fantasy" in stories and may become confused by magical effects, believing them to be possible in real life.

Wholesale generalizations about the effects of television, especially if they are unqualified condemnations, are not particularly useful. For example, Japanese children watch a considerable amount of television and yet also spend two to three hours an evening doing homework, as opposed to the approximately one-half hour that U.S. children average. Perhaps the best generalization that can be made is that the effect of television on children should not be viewed in isolation from the overall constellation of factors that structure children's lives.

TABLE 7-4 Hours Per Day Spent Watching TV, Grades 6, 8, and 12, 1979–80 through 1986–87

	1979–80	1983–84	1984–85	1985–86	1986–87
Grade 6					
0–1	28	13	15	16	15
1–2	23	17	18	24	18
2–3	17	20	20	27	20
3–4	11	17	17	13	16
4+	21	32	30	19	29
	100%	99%	100%	99%	98%
Average	2 hrs., 14 mins.	2 hrs., 47 mins.	2 hrs., 47 mins.	2 hrs., 43 mins.	2 hrs., 40 mins.
Grade 8					
0–1	—	14	15	15	15
1–2	—	18	19	19	19
2–3	—	20	21	22	21
3–4	—	17	17	17	16
4+	—	31	28	28	28
		100%	100%	101%	99%
Average		2 hrs., 50 mins.	2 hrs., 44 mins.	2 hrs., 43 mins.	
Grade 12					
0–1	30	37	—	30	31
1–2	22	23	—	24	26
2–3	19	17	—	17	19
3–4	13	10	—	9	10
4+	16	13	—	12	14
	100%	100%	—	92%[a]	100%
Average	2 hrs., 8 mins.	1 hr., 53 mins.	—	2 hrs., 2 mins.	2 hrs., 6 mins.

[a] Missing data

SOURCE: California Department of Education.

Music

Young people spend about one-fourth to one-fifth as much time listening to music as they do watching television. From the perspective of youth, however, there are important differences between television watching and listening to music. Although television viewing is more often experienced as a family event, listening to music is either a solitary activity or done with peers. Whereas television addresses a broad audience, including adults, teen music is produced by singers and composers who are often much closer in age to those for whom the music in intended and very often reflects issues characteristic of youth: sexuality, alienation, and autonomy.

Obviously, music brings pleasure to many children and youth. Beyond this, we cannot say what exposure to music means for the condition of California's children. Although supporters and critics of various types of music abound, there are no studies of the impact of music on other aspects of children's well-being.

Employment

To a degree largely unrecognized, a substantial proportion of young people spend a significant portion of their time at gainful employment. In fact, for at least half of all older teenagers, this is their major activity outside of school.

Even before reaching adolescence, most children do some work, largely in the form of household chores. The best California data again are from the Medrich study. Most children in Medrich's group performed various chores around the house. Children of working parents performed more chores than those where only one parent was employed, but there was little difference in chores between one- and two-parent households. The chores performed by children differed by sex, with boys more frequently doing "masculine" tasks such as emptying the garbage and girls more frequently setting the table.

Fifteen percent of 11- and 12-year-olds in Medrich's Oakland study worked outside their homes, usually once or twice a week, with the most common jobs being paper routes, yard work, and babysitting. The median earnings from these jobs in the middle 1970s was $4 per week, compared to median allowances of $1.50 per week. More than half of those who worked spent their money on candy and other nonessentials; only a quarter of the children earning money said that they saved part of their earnings.

At the high school level, teenagers are working at ever-increasing rates. In 1986, only one in five high school seniors in the western United States did not perform any paid work. On the other hand, almost one in ten (9.4 percent) seniors worked over 30 hours per week during the school year, and almost half (45.6 percent) worked 16 hours or more per week.

About the same number of girls as boys worked during out-of-school hours, and girls and boys worked about the same number of hours. The jobs held by young people tended to be sex-stereotyped: girls gravitated toward babysitting, secretarial, sales, and food service positions. Boys also worked in the food industry, but they worked in service jobs and as laborers and craftspeople far more than did girls.

This overall situation is in dramatic contrast to that of 1940, when the U.S. Bureau of Labor Statistics started to keep track of youth employment. In that year, only 9 percent of 14- to 16-year-olds worked, and only 2.4 percent were working and going to school at the same time. Compared to 1940, a 16-year-old youth is five times more likely to work part-time today, and young women of the same age are sixteen times more likely to be employed.[6]

Impact on Children's Well-Being

A number of critics question the value or effects of increasing student employment. For example, Laurence Steinberg and Ellen Greenberger have concluded, on the basis of a recent study of working high school students in Orange County, that the work ethic may be a casualty of youthful work experiences. Youth become cynical about the pleasures of productive labor, they report. Only 4 percent of the Orange County students said that they went "beyond the call of duty" in the performance of their jobs.[7]

Based on surveys of high school seniors, Bachman et al. observe that very few high school students regard part-time employment as a way of preparing for later life, as a way of spending productive time, or as a way of developing solid work habits.[8] They are far more likely to view employment as a source of money for the purchase of clothes, cars, stereos, movies, and other consumer goods. In surveys of parents, some have expressed concern that this discretionary income lessens parental control and may facilitate alcohol or drug use.

Evidence also exists for the positive, or at least benign, effects of work. A recent study by the William T. Grant Foundation reviews the literature on youth employment and reports that, although the effect of working on grades is unclear, the weight of the evidence supports the conclusion that students who work less than twenty hours per week do not seem to do less well in school.[9] The authors also believe that working during high school promotes desirable work habits and may help those students who do not plan to go to college to obtain first jobs. They report that the limited amount of research also indicates that, generally, although working students do spend less time with their families, relationships with their parents and siblings are not affected negatively by working. The study also finds that most youth do not learn important skills from working; young people work mostly at minimum-wage jobs and they do so to have spending money, not because they like work or because they are helping to meet family expenses.

One finding is consistent throughout the literature: young people from middle-income homes are much more likely to work during high school than are youth from lower-income homes. Thus, to the extent that work experience helps youth acquire skills, obtain future employment, or just have more cash available, those who might benefit most either do not choose to work or do not have access to jobs. More information is needed to determine the reason for the variation by economic group (there also are ethnic differences). Further research also is needed regarding the impact of work on school performance and long-term career prospects.

Conclusion

There are many aspects of children's everyday experience that we have not addressed in this chapter. For example, while we examined television habits, we did not look at leisure-time reading patterns. Also, we focused on employment, but we did not comment on play that is not structured in organized athletics. In short, however broad and expansive this chapter has been, there are substantial amounts of time for which we have not accounted.

Because of limited data, it is difficult to draw any conclusions about the well-being of children on the basis of descriptions of their neighborhoods or how they spend their time. Yet we have little doubt that the quantity and quality of neighborhood resources influence children's development. We do not assert that any particular activity is necessary for a child's development or that some activities are better than others. Rather, we believe that the well-being of children is maximized when a variety of options are available that appeal to different children's interests and that expose children to a range of experiences that provide pleasure, learning, and an opportunity for personal growth.

Society contributes to meeting the needs of children when adequate activities are accessible to all children, regardless of where they live or their families' income, when the activities are run by caring and trained adults, when the activities are appropriate to the child's stage of development, and when children's physical environments provide safe, healthy, and interesting settings to facilitate their emotional development.

Chapter 8

Health

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A consideration of children's health should examine more than impaired functioning and the absence of disease. Children experience an extensive and constantly vulnerable process of physical, intellectual, and emotional development that affects the child's immediate and future well-being. Furthermore, beginning in the prenatal months, social, cultural, and economic factors influence conditions that affect the health of the growing child. Viewing children's health from this perspective requires paying particular attention to the changing conditions of family life, the relation of social conditions to unhealthy lifestyles that create health-endangering risks for children, poverty and its effects on children, and the special importance of early identification and prevention in promoting health and avoiding dysfunction.

Medical and public health developments in this century have substantially improved children's health. Infant mortality has declined dramatically, treatment of childhood infectious diseases has improved, and immunization has virtually eliminated several previously common childhood illnesses. Nevertheless, there are still too many children whose current health and future prospects are endangered, not primarily by "germs," but by a wide range of factors less amenable to immunization– for example, the effects of poverty, poor nutrition, parental neglect, adult drug and alcohol abuse, physical and sexual assaults from adult "caregivers," and stresses leading to irrational and risk-taking behaviors.

Poverty emerges as a central theme in understanding the incidence of health-harming conditions for children. Although poverty is conventionally identified by income level, it involves more than merely insufficient money to purchase food, housing, and other necessities. Conditions of poverty typically also include poor nutrition, crowded living conditions, higher than normal exposure to infectious diseases, and unsanitary environments. Families living in poverty more often experience problems such as substance abuse, unemployment, and other persistent stress. These and other conditions have serious consequences for the capacity of families to support the healthy development of children. In addition, children in poverty are often disadvantaged in terms of access to high-quality health services that could prevent, diagnose, and treat their health problems.

Effective policies for improving children's health should be based on a broad perspective that acknowledges the need to provide preventive, early identification, plus diagnosis, treatment, and rehabilitative services to address problems. Potential problems and specifiable risk in the medical, developmental, emotional, and family domains also need to be addressed. Such a comprehensive approach is especially crucial for impoverished families who are confronted with fragmented and inadequate services.

The Changing Issues

Advances in children's health since the turn of the century have been striking, resulting in the rapid decline of historically high rates of infant mortality and childhood disease and mortality. Also remarkable have been the effects of advances in public and domestic sanitation, the use of antibiotics, and the development and use of immunizations for many common childhood illnesses. These developments have contributed to a decline in the incidence and severity of childhood illnesses. Childhood infectious diseases such as whooping cough and diptheria have become rare. In addition, most common illnesses that remain, such as ear infections and influenza, can be effectively treated to diminish discomfort and prevent complications.

Although the general improvement in children's health is gratifying, there are notable and troubling differences in mortality and morbidity rates according to children's socioeconomic status, race, ethnicity, geographic region, area of residence, and gender. The great improvements in child health from the prevention and treatment of disease have also reshaped the nature of childhood morbidity and mortality. Accidents and violence, for example, have increased in importance relative to infectious diseases as causes of child mortality and disability. In addition, some children suffer from serious chronic disabilities. The numbers of these exceptionally needy and often fragile children may be increasing as a result of medical technologies capable of correcting life-threatening conditions in infants. These infants live, but often suffer disabilities that compromise the quality of their lives.

Despite the triumphs of scientific medicine, many health problems of children persist and new problems are emerging. The so-called new morbidities afflict children with behavioral, emotional, and familial problems—such as suicide, accidents, conditions related to risk-taking behavior, and parental abuse. These are not really new; but they are becoming more predominant as "old morbidities" are overcome by medical advances. The health problems stemming from the "new morbidities" will not be so easily overcome as, for example, the single scientific breakthrough of the polio vaccine. There is seldom a single identifiable and treatable cause for drug abuse, teen pregnancy, risk-taking sexual behavior, or alcohol-related problems. These problems require social, cultural, and educational interventions to complement more purely medical contributions. Such interventions are difficult to identify, target, and sustain with sufficient intensity to make a difference. Furthermore, the fragmented delivery of many health, developmental, and related social services makes the coordination of multiagency services and the integration of program efforts a very difficult task.

The complexity of conditions affecting children's health also highlights the importance of availability and access to appropriate health services. Access to health care, especially high-quality, comprehensive health care, remains a problem, particularly for the uninsured and for some disadvantaged minorities. One or both parents of many children cannot afford to purchase health insurance, and work in low-wage jobs that do not provide health insurance as a fringe benefit. Even when insurance coverage exists, it is often inadequate and incomplete, and tends not to include preventive, early identification, and case management services.

Four trends are intensifying the problem of health coverage for children. First, health care costs are prohibitively expensive to pay out of pocket, so that most people must rely on health insurance, even for routine preventive care. Second, increased competition in the health care marketplace, manifested by the increase in managed-care plans—that is health maintenance organizations (HMOs), preferred provider organizations (PPOs), and independent practice associations (IPAs)—has introduced new cost-saving incentives. Physicians are increasingly required to provide health services to patients at a discount. Thus, as insurers reduce reimbursement rates, many physicians are less willing to provide services to MediCal patients. Third, the state apparatus that administers health care and health insurance coverage for the poor is engaged in a major cost-cutting effort and is reluctant to expand programs for poor children. Finally, poverty in California is growing.

Determinants of Health and Well-Being

The infant enters the world already deeply affected by genetic endowments and environmental influences that interact to shape the child's development. Prenatal and perinatal factors are affected by the mother's health and behavior, which is in turn tied to a complex set of conditions of family life, class, race, income level, and culture. As the child develops, similar complex interactions of genetic, physical, social, and cultural factors continue to affect his or her health and well-being.

The health care delivery system is obviously a key influence on children's health. For the purposes of this report, this system is understood to consist of a wide range of programs that may not be solely medical in nature but do clearly contribute to the health of children. Examples of nonmedical, health-related programs are school breakfast and lunch programs, health screenings performed at schools, child care services, and family support services.

Children are provided health care by a complex patchwork of private and public agencies. "Medical services" are diagnostic, treatment, and, to a lesser extent, preventive services provided by physicians. Such services are mostly negotiated privately by families and their doctors, financed through private insurance, health maintenance organizations (HMOs), and publicly funded programs such as MediCal. Developmental and mental health services may be provided by physicians, but are also provided by other health and education providers, by private providers, schools, and other community agencies.

One important goal of public health promotion efforts has been to increase access to health care. The 1965 Medicaid and the Early Periodic Screening Diagnosis and Treatment (EPSDT) programs provide poor children with state-financed access to basic medical and preventive services. In the 1970s, statutes like the Education for All Handicapped Children Act (Public Law 94-142) directed the public schools to assume a larger role in the provision of basic health and rehabilitation services to handicapped children. Extension of the Education for All Handicapped Children Act through Public Law 99-457 provides early identification and treatment services for children 0 to 3 years old who are presumed to be at risk for ongoing developmental disabilities. Another significant policy approach has been to provide services to children with specialized needs. The Crippled Children's Program in California established in 1927 (now called California Children's Services) to provide medical services to handicapped children became the model for the crippled children's programs nationwide that serve children with a range of serious disabilities.

Unfortunately, even successful programs serve only a small percentage of eligible children because of limited outreach and insufficient funding. Programs aimed at improving children's health tend to be both fragmented and administered by complex bureaucracies. Existing categorical programs do not adequately address the health needs of the growing numbers of very high-risk children (such as children in foster homes, *in utero* drug-exposed children, infants born with HIV infection, and homeless children).

Health Goals

At the heart of the complexities and obstacles faced by those concerned with children's health is the almost complete absence of an overarching policy directed toward addressing the health and developmental needs of California children. Although steps have been taken to identify and serve children with well-categorized needs, a policy that could guide efforts to fill in service gaps or to improve coordination with other child-oriented efforts has never been articulated. Such a policy would define good health, gather data related to children's health, conduct a needs assessment, and propose programs for addressing the needs. Such a policy would state goals for the minimum levels of health that society hopes to maintain for its children. It would also acknowledge the essential role that parents and families play in assuring children's health and would commit society to providing the multiplicity of supports parents and families require.

Methodology

This chapter documents the health status of California's children. Several health status measures for children in general and for selected demographic groups of children are reviewed. Note that the data in these areas are inadequate, except for single measures of mortality. Prevalence of many disorders can only be estimated on the basis of the number of children using certain health programs, and such measures are seriously flawed.

Illness and injury vary greatly in the intensity of their effects on an individual's health. Conceptually, "five Ds"—death, disease, disability, discomfort, and dissatisfaction—can serve to define the experience of ill health. Of these conditions, death and disease are easier to identify and measure than are disability, discomfort, and dissatisfaction. Nevertheless, like the "new morbidities," these last three "Ds" have risen in prominence as medical advances have improved conditions for children with respect to death and disease. Because state data collection has not yet reflected this trend, we lack comprehensive information on the less easily measured health measures.

This chapter also examines various types of health service programs, those developed to meet special needs as well as those developed to address the health care needs of all children in the state. The diversity of such programs is a product of the piecemeal growth of services, which reflects the historical process whereby particular health-related issues became concerns for public policy. A general conclusion of the examination is that child health services pay insufficient attention to social causes of illness and steps that could be taken to prevent poor health outcomes. The recent rise in the infant mortality rate, although temporary, should remind policymakers and health care professionals that they must maintain a lively vigilance if health care programs for children are to continue to improve.

The Health of Children

Measuring Health and the Use of Health Care

A detailed report on the health of children in California should begin with a general overview of the health status of children and their use of medical services. Data routinely collected by the National Center for Health Statistics include three different measures of health status.[1] Taken together, these data suggest that California children are generally healthy. Only a small number, fewer than 10 percent of California children, are considered to have severe health problems and/or chronic disabilities that limit their activities. Only poor children are consistently more likely to be ill or assessed by their parents to be in ill health.

The first measure, "perceived health status" (Table 8-1), reflects the responding parent's overall assessment of his or her child's health. Clearly the vast majority of children in California are considered to be in excellent or very good health by their parents. Although quite subjective, this indicator has proved to be an accurate predictor of children's future health status and likelihood of using medical services. Fewer than one in every twenty California children is reported to be in only fair or poor health and parents' assessments of health status are similar for children of different ages, sexes, and races. Parents of poor children, however, are two to three times more likely to report that their children are in fair or poor health (6.3 percent compared to 2.4 percent); concomitantly, parents of poor children are far less likely to report that their children are in "very good" or "excellent" health (57.6 percent compared to 41.5 percent).

Children in low-income families also appear to be less healthy than their more affluent counterparts on the second health status measure: "days spent ill in bed." This measure includes days confined to bed as the result of acute as well as chronic conditions. California children are reported to spend an average of five days each year in bed because of illness. This varies little by age, sex, or race. Poor children, however, are reported to spend an average of 6.7 days in bed annually compared to 4.4 days for children in households where income exceeds the poverty line.

The third health status measure is "limitation of activity due to chronic conditions." Chronic conditions such as allergies and respiratory diseases are quite common among children, but most children's chronic conditions do not cause long-term limitations on their activities. However, about 5 percent of California's children are limited in their school, play, and recreational activities by chronic illnesses, as shown in the last column of Table 8-1. Limitation of activity is more commonly reported for older children and for boys, and is somewhat less commonly reported for minority children.

Use of health services as indicated by frequency of physician contacts and hospitalizations is shown in Table 8-2. Impoverished children spend twice as many days in the hospital as children in

TABLE 8-1 Health Characteristics of Children Under 17 Years of Age, California, 1984–85

	Perceived Health Status			Average Number of Days Spent Ill in Bed Annually	Limitation of Activity due to Chronic Conditions	
	Excellent	Very Good	Poor		Limitation	No Limitation
Age						
All	55.1%	41.8%	3.1%	4.8	4.8%	95.2%
Under age 6	56.5	39.8	3.7	5.1	3.1	96.9
Ages 6 to 17	54.3	42.9	2.8	4.6	5.7	94.3
Gender						
Male	55.4	41.4	3.2	4.5	5.2	94.8
Female	54.7	42.3	3.0	5.1	4.4	95.6
Race						
White	55.2	41.9	2.9	4.9	5.1	94.9
Nonwhite	54.4	41.5	4.1	4.4	3.6	96.4
Poverty Status						
Above poverty	57.6	40.0	2.4	4.4	4.6	95.4
Below poverty	41.5	52.2	6.3	6.7	6.5	93.5

families whose incomes are above the poverty line. Minority children also spend about twice as much time hospitalized as white children.

White children, on average, visit a doctor more than one and a half times as often as minority children. By about the same margin, children in families above the poverty line exceed poor children in the number of times they visit a doctor annually. On average, children in California contact physicians four times annually for treatment of existing conditions, diagnoses, and preventive services.

Table 8-2's second column, reporting the last time a child visited a physician, provides a good indicator of the ease with which California children are able to gain access to health care. By this measure, again, poorer children are worse off, as are children in families with older children. Eleven percent of minority children, compared to 8.6 percent of nonminority children, have not visited a doctor within the past two years. The American Academy of Pediatrics recommends that all children receive checkups and supervisory care visits to a doctor at least once every two years; annual or more frequent visits are recommended for children under age six.

Among young children especially, most visits are for preventive services and routine care of acute conditions such as colds and minor injuries. It is probable that the greater number of poor and minority children who are not receiving these routine treatments may account, in part, for their greater rates of hospitalization. The lack of preventive care may lead to more serious ailments that must be treated in hospitals and that are far more costly, in financial terms as well as in terms of pain, disability, and trauma to children.

TABLE 8-2 Use of Health Care Services by Children, California, 1984–85

	Ambulatory Care		Hospital Care	
	Average Annual Doctor Contacts	Percentage Without a Contact in Last Two Years	Hospital Admissions per 100	Hospital Days per 1,000
Age				
All	4.0	9.3%	4.0	207
Under 6	6.4	1.6	6.9	427
6 to 17	2.6	13.5	2.5	89
Gender				
Male	4.3	9.8	4.6	221
Female	3.6	8.8	3.5	192
Race				
White	4.2	9.5	3.9	172
Nonwhite	2.7	8.6	4.9	368
Poverty Status				
Above poverty	4.3	8.6	4.1	171
Below poverty	2.9	11.0	4.5	347

Even though the statistics presented indicate that the majority of California children enjoy good health, there are still serious exceptions that must be addressed. Many 2-year-olds do not get the proper immunizations; a significant percentage of children do not receive adequate medical supervision; and social maladies, exacerbated by economic and cultural factors, are striking children with ever greater ferocity and are difficult to measure using more general measures of health status. Although the numbers indicate superficially that children are in generally better health than adults, these figures should not be accepted uncritically.

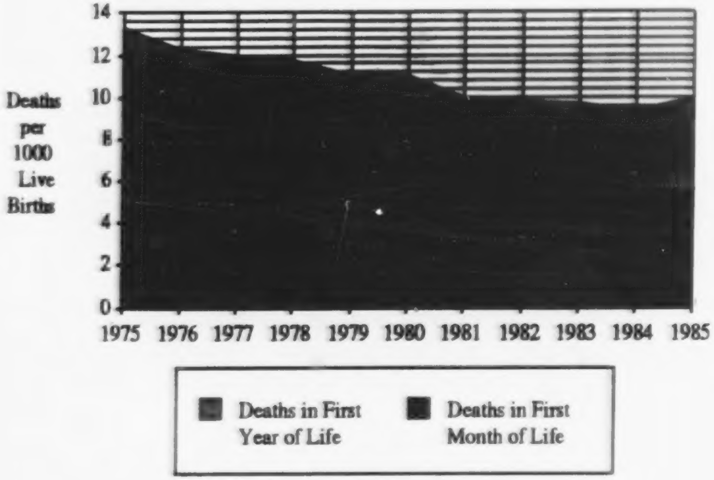
Many health problems or threats are now considered preventable. Unlike earlier maladies, such as polio before the advent of vaccines, few diseases that strike children are considered untreatable. But medical expertise does not always reach those who need it. A substantial portion of California's infant mortality rate is considered preventable, for example, yet the rate is rising rather than falling.

Infant Morbidity and Mortality

Infant morbidity and mortality are very complex problems, and demand a great deal of public attention. Although there is no easy solution to the problems of infant morbidity and mortality, many modifiable risk factors have been identified, and treatments have been developed—the most important of which is early comprehensive prenatal care. This section discusses trends in infant mortality and morbidity, the contribution of prematurity and low birth weight, risk factors that influence birth weight and prematurity, and the role of prenatal care.

The infant mortality rate is recognized worldwide as an important general index of the health status of populations.[3] The U.S. infant mortality rate has fallen steadily in this century and dramatically between 1960 and 1981. But the United States still has a higher infant mortality rate than most other industrialized nations (ranking twentieth in 1983), and the rate of decline in infant mortality has slowed considerably in recent years.[3] California's infant mortality rate has traditionally been low compared to other states (seventh in 1970). But recent statistics show California's rank as only thirteenth in 1985.[4] In fact, in 1985, for the first time California's infant mortality rate actually rose above the previous year (Figure 8-1). The slight rise in infant mortality is inconsistent with the state's generally high standard of living, per capita income, medical care expenditure, as well as previous annual declines in infant mortality.

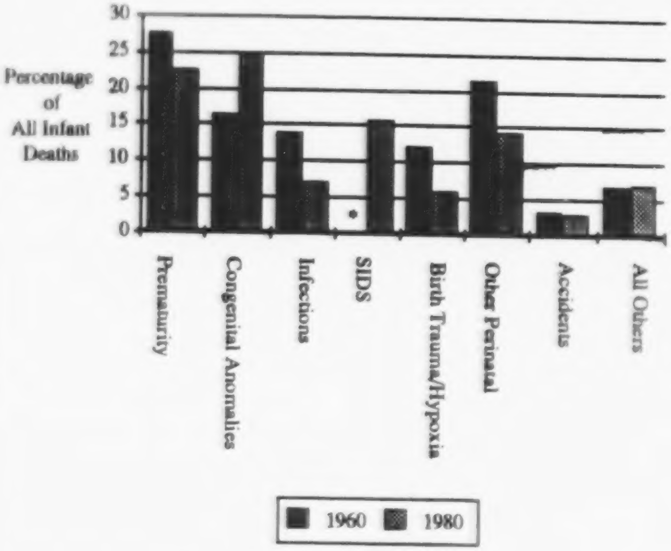
FIGURE 8-1 Rates of Infant Deaths in California, 1975–1985



SOURCE: State of California, Department of Health Services, Maternal and Child Health Branch.

Infant deaths have a variety of causes, but the two primary causes are prematurity[5] and birth defects (congenital anomalies). About one-quarter of infant deaths are due to prematurity-related respiratory conditions and one-quarter to birth defects (Figure 8-2). However, if all prematurity-related diagnoses are combined, being born too soon accounts for at least 45 percent of infant deaths.[6] Thus prematurity is considered the leading cause of death in infants.

FIGURE 8-2 Causes of Infant Deaths in California, 1960 and 1980



*Less than 0.1 percent.

SOURCE: Lilo Strauss, Division of Reproductive Health, Center for Disease Control, 1987.

In California as in other states, great strides were made in the 1970s to reduce infant deaths due to prematurity largely through intensive hospital care of newborns.[7] But there was little progress in reducing the incidence of premature births themselves. Several state programs for the care, financing, and followup[8] of infants treated in neonatal intensive care units have developed over the last fifteen years, and for the most part did not require that a family be classified as low income to establish eligibility for services. However, few state programs were aimed at preventing premature births.

Because it is easier to determine whether a baby's birth weight is less than 2,500 grams (the "low birth weight" definition, equal to 5 pounds and 5 ounces) than to judge whether its gestation is less than thirty-seven weeks, and since most babies in the United States whose birth weights are low are in fact premature, low birth weight rates have become a widely used index of potential infant morbidity and mortality. Preventing low-weight births has become a major public policy objective in this decade because of its great promise for improving infant survival and long-term outcome.[9] Not only is low birth weight a risk factor for infant mortality, but most other risk factors appear to exert their effects on early infant mortality (in the first month of life) through their effects on birth weight.[10] Low birth weight babies are not only far more likely to die than other babies, they are more likely to be sick and to develop chronic illnesses and developmental disabilities. Low birth weight babies are more likely to need intensive hospital care when born and hospitalization through the first year of life.[11] They are at risk of developing mental retardation and other developmental disabilities that can persist through life.[12] Preventing low-weight births should reduce the need for neonatal intensive care after birth. Neonatal intensive care is not only expensive, but also only partially effective at reversing many problems that could be prevented before birth.

After little change in the low birth weight rate in California since 1979, the highest rate was recorded in 1984 (6.4 percent). Low birth weight can become associated with several demographic, medical, behavioral, and environmental risk factors (Table 8-3). As with infant mortality rates, low birth weight rates are highest for families of low socioeconomic status.[13] Whether measured by income, education, or ethnicity, low socioeconomic status has long been recognized as a risk factor for low birth weight. In addition, conditions associated with poverty, including lack of education, poor nutrition, substance abuse, and persistent stress, have been documented to contribute to a higher risk profile. A sixfold increase in the risk of low birth weight was found in Oakland to be associated with women with financial problems during pregnancy, even after controlling for other risk factors including race, poor health habits, and complications of pregnancy.[14]

The demographic risk factor with greatest impact on birth weight is race, and black babies are most at risk (Figure 8-3). The ratios of black to white infant deaths, and of low-weight births, have widened in the 1980s in California.[15] An unexplained black-white difference in the prevalence of low birth weight seems to persist even when all other known socioeconomic variables are accounted for. In spite of this residual difference, many interventions of proven efficacy can be employed to reduce current differences. Other maternal risks include lack of education, low income, maternal age younger than 17 or older than 34, and unmarried status.

The demographic and medical risks of low-weight births can generally be identified and modified even before pregnancy begins. Improving low birth weight rates involves reduction of the risk factors whose effects are reversible, such as substance abuse (cigarettes, alcohol, or drugs), and poor nutrition. In this way, pregnant women who modify their risk behaviors while pregnant can improve the chances that their infants will not be of low birth weight (currently, the rates are, for blacks, 3.5 percent; for whites 1.6 percent).[16]

TABLE 8-3 Principal Risk Factors for Low Birth Weight

I. Demographic risks
  - A. Race (black)
  - B. Low level of education
  - C. Low socioeconomic status
  - D. Age (under 17 or over 34)
  - E. Unmarried status

II. Medical risks predating pregnancy
  - A. Parity (0 or more than 4)
  - B. Low weight for height
  - C. Genitourinary anomalies or surgery
  - D. Selected diseases such as diabetes and chronic hypertension
  - E. Nonimmune status for selected infections such as rubella
  - F. Poor obstetric history, including previous low birth weight infant, multiple spontaneous abortions
  - G. Maternal genetic factors (such as low weight at mother's own birth)

III. Medical risks in current pregnancy
  - A. Multiple pregnancy
  - B. Poor weight gain
  - C. Short interpregnancy interval
  - D. Hypotension
  - E. Hypertension, preeclampsia, and/or toxemia
  - F. Selected infections such as symptomatic bacteriuria, rubella, and cytomegalovirus
  - G. First- or second- trimester bleeding
  - H. Placental problems such as placenta previa, abruptio placentae
  - I. Hyperemesis
  - J. Oilgohydramnios or polyhydramnios
  - K. Anemia or other abnormal hemoglobin
  - L. Isoimmunization
  - M. Fetal anomalies
  - N. Incompetent cervix
  - O. Spontaneous premature rupture of membranes

IV. Behavioral and environmental risks
  - A. Smoking
  - B. Poor nutrition
  - C. Alcohol and other substance abuse
  - D. DES exposure and other toxic exposures, including occupational hazards
  - E. High altitude

V. Health care risks
  - A. Absent or inadequate prenatal care
  - B. Iatrogenic prematurity

VI. Evolving concepts of risk
  - A. Stress both physical and psychosocial
  - B. Uterine irritability
  - C. Events triggering uterine contractions
  - D. Cervical changes detected before onset of labor
  - E. Selected infections such as mycoplasma and chlamydia trachomatis
  - F. Inadequate plasma volume expansion
  - G. Progesterone deficiency

SOURCE: Institute of Medicine, 1985.

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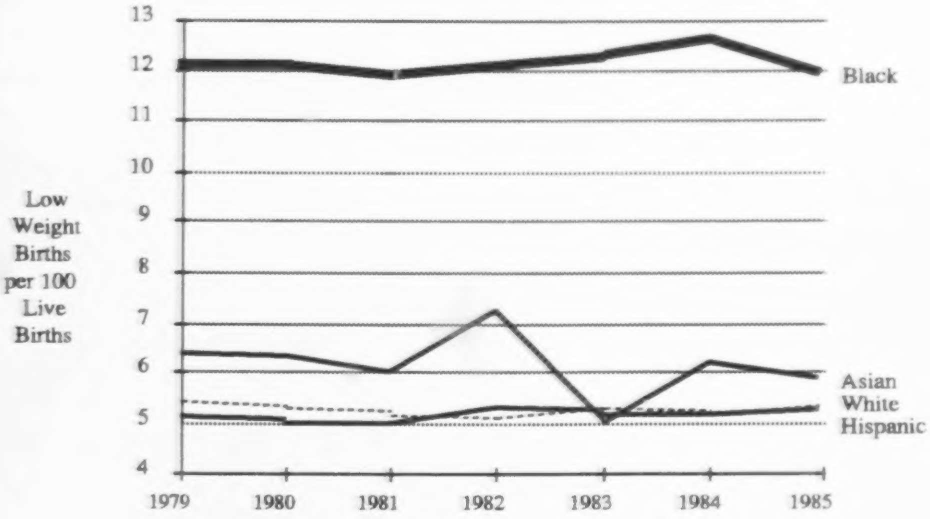
FIGURE 8-3 Low Birth Weight Rates in California by Ethnicity, 1979–1985



SOURCE: State of California, Department of Health Services, *Vital Statistics*.

Role of Prenatal Care. While prenatal health services cannot ameliorate all risk, prenatal care can help to overcome some of the impact of socioeconomic conditions on low birth weight and therefore on infant morbidity and mortality. Health care during pregnancy involves early determination of a patient's risks, continual support of the efforts to reduce the risks, and repeated monitoring of physical signs and symptoms of pregnancy complications. Appropriate treatments can be introduced at any point during pregnancy whenever signs and symptoms are detected. While demographic risk factors (such as race and age) are not affected by health care during pregnancy, a number of the behavioral and environmental risks (such as cigarette smoking) are, like medical risks (such as hypertension), amenable to appropriate interventions. Studies have provided statistical evidence that the impact of prenatal care on infant mortality is mediated through its effects on improving birth weights.[17]

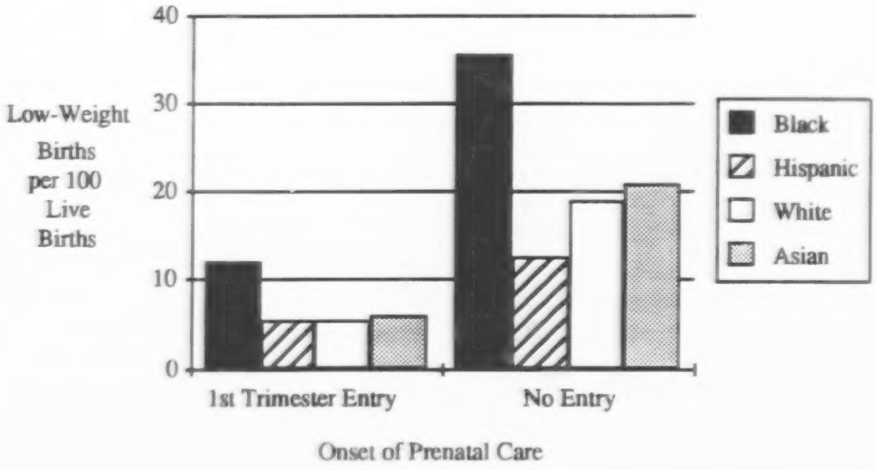
Infant low birth weight and mortality rates are markedly higher for pregnant women who obtain no prenatal care (Figure 8-4). California, however, has fallen in rank among the states (from tenth in 1970 to thirty-fourth in 1985) in the proportions of births in which prenatal care begins early in pregnancy. In 1985, thirty-two states had lower proportions of women with late or no prenatal care than California.[18] To improve such statistics, barriers in access to early and continuous prenatal care need to be reduced. Since 1987 the California Department of Health Services has implemented policies to ensure both the improved quality of and access to prenatal care for low-income women.

In 1987 the Department of Health Services began selectively certifying providers of "comprehensive" prenatal care, a special package of services for low-income pregnant women previously demonstrated to be effective in improving birth weight outcomes in a pilot study from 1979 to 1982.[19] Entitled the OB Access Project, the pilot study of comprehensive care included not only the surveillance of clinical risks and treatments for any symptoms that developed, but also cause coordination, health education, and nutritional and psychosocial services to reduce risks found most prevalently in low income women. Clinical services that only emphasize abdominal palpation, urine and blood testing, and crisis management for complications are generally not sufficient to reduce the prevalence of preterm births.[20] These important expanded services were most often given by nurse midwives or nurse practitioners. Although the expanded care cost more, the savings in neonatal intensive care to MediCal alone demonstrated overall cost reductions of at least $1.70 saved for every dollar spent on the program.[21] Service similar to the pilot program eventually became the statewide Comprehensive Perinatal Service Program that began serving pregnant women in 1988. Currently more than one hundred "Comprehensive Perinatal Service" providers are certified to provide comprehensive care to low-income pregnant women in the state of California. These providers, however, serve only a small portion of all MediCal-eligible pregnant women. Efforts must still be made to see that ever larger portions of MediCal women have access to the effective comprehensive care demonstrated in the OB Access Project.

Families of low socioeconomic status face particular challenges in finding and using effective prenatal health care; challenges may be related to their lower incomes, shorter formal education, and cultural backgrounds.[22] These problems have been aggravated in the 1980s by changes in the economy and the health insurance benefits provided by many employers that have left ever larger proportions of the population—particularly women, and especially minority women—unable to afford private health insurance.[23] Uninsured pregnant women tend to enter the health care system later and use more expensive resources.[24] Pregnant women eligible for Medicaid-reimbursed care early in pregnancy make better use of prenatal care services.[25]

In 1988, the state of California expanded the eligibility criteria for MediCal benefits during pregnancy. The amount of money a family can earn and still be eligible for prenatal care was increased from 100 percent to 185 percent of the federal poverty standard. This measure is designed to reduce the proportion of low-income pregnant women who are uninsured for maternity

FIGURE 8-4 Low Birth Weight Rates in California by Onset of Prenatal Care



SOURCE: State of California, Department of Health Services, *Vital Statistics*.

care. MediCal will also be obligated to provide care to many pregnant women who in the past faced difficulties obtaining MediCal eligibility because of their naturalization status. The state has designated that pregnancy will be one of the emergency categories defined in the federal OBRA-IRCA legislation that MediCal will reimburse for aliens. The challenge now is to see what proportions of uninsured women actually benefit from the change in policy, receive MediCal eligibility early and continuously throughout pregnancy, and have access to comprehensive prenatal care in proportion to their needs.

With larger numbers of women eligible for MediCal reimbursed prenatal care, the most urgent problem facing policymakers is to ensure sufficient obstetric care to provide early, continuous, and comprehensive services for MediCal women. Obstetricians have notoriously lagged behind other specialties in their willingness to provide care to women whose third-party payor is MediCal.[26] The situation has only become worse in the 1980s with the serious strains of increased professional liability costs to obstetric providers, in the private and public sectors, and for clinic and office-based providers.[27] In 1988, the California Department of Health Services increased the rate that obstetric providers will be paid for prenatal care and delivery services for MediCal-eligible women. The rate that providers are to be paid by regulation in 1989 should be nearly 80 percent higher than that paid in 1984, although this rate is still at least 30 percent lower than that generally paid by private insurance companies. Whether these rates will be sufficient to expand the availability of providers to low-income pregnant women will be a key issue.

California has gone a long way in the past two years to see that a credible effort is made to prevent premature births and avoidable infant morbidity and mortality. However, the vital statistics of births in the state must be scrutinized to determine whether the promise of recent actions proves fruitful in the end. Will the proportions of women uninsured for prenatal care decline as expected? Will the proportions of low-income women who obtain early and continuous prenatal care increase? Will the gap narrow between the rates of low birth weight and infant mortality for blacks and for other racial and ethnic groups? There are further steps the state could take now to improve the chances of healthier infants at birth.

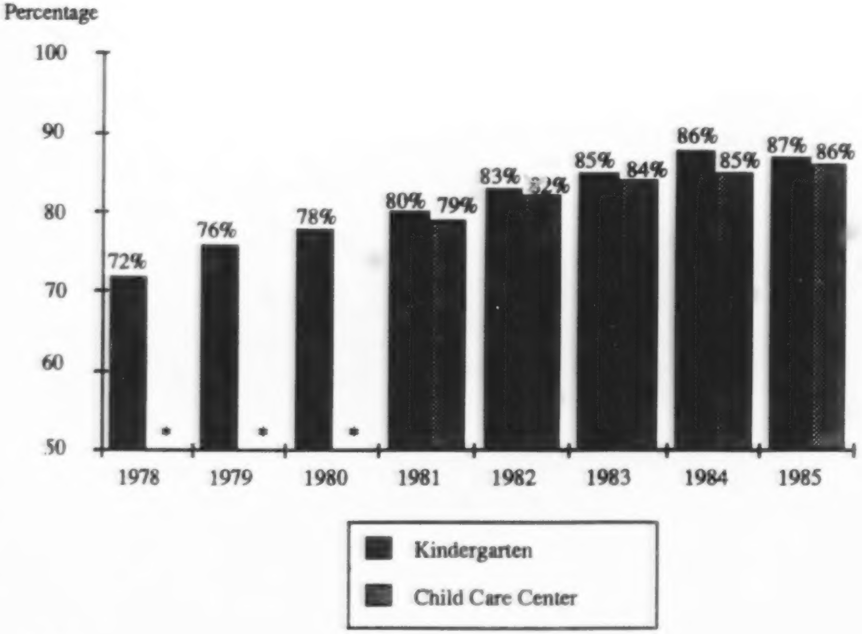
In its Budget Reconciliation Acts, the federal government has indicated that more can be done to make federal matching Medicaid funds available for pregnant low-income women. One federal provision not yet adopted by California is "presumptive eligibility," which takes effect when a woman first appears for prenatal care, in order to prevent the delay in beginning risk reduction measures. A second provision yet to be adopted is that of "continuous eligibility," which extends medical coverage six weeks after birth once MediCal eligibility is confirmed to ensure that continuity of care is not interrupted even if circumstances that jeopardize MediCal eligibility develop. Clearly, an evaluation of California's recent efforts to reduce low birth weight rates and infant mortality by expanding access of low-income women to prenatal care will be crucial in ascertaining whether enough has been done to remedy the problems recent state actions seek to address.

The Health of Children Ages 1–12

At one time, growing up was perilous and risky, and each child ran a very high risk of being struck down by disease. Dying young was, in fact, a good possibility for many. This is still the case in many parts of the world. But in America, the coupling of medical science and vastly improved public health practices have made childhood a far safer journey through time.

Immunizations. One of the most effective efforts to improve the health of children has been the development of immunizations for common diseases. The percentage of children who have been immunized for vaccine-preventable diseases such as measles, rubella, and mumps has risen steadily as the result of stronger compulsory immunization laws and their strict enforcement (Figure 8-5). Currently, in fact, more than 97 percent of all California kindergarteners have received adequate immunization for measles, rubella, and mumps. Levels of DTP (diphtheria, tetanus, and pertussis) and polio vaccinations, at 92 percent to 93 percent respectively, are slightly lower. The difference in these figures probably results from the difficulty of making sure a child receives the entire series of vaccinations.

FIGURE 8-5 Percent of Pupils Unconditionally Admitted (Meeting All Requirements), Kindergarten and Child Care Center Children, California, 1978–1985



* n.a.

SOURCE: California Department of Health Services, Immunization Unit.

Immunizations were first required for entering school in 1961, but comprehensive, rigorous enforcement of the school immunization law and related regulations did not begin until 1978. The immunization law has since been modified to require even more types of immunizations, and more rigorous proof of immunization. The requirements apply to any public or private elementary or secondary school, child care center, day nursery, nursery school, or developmental center.[28] Students under age 18 must show evidence of adequate immunization against diphtheria, tetanus, polio, measles, and rubella. Before age 7, students must prove they have been immunized for pertussis and mumps.

The result of such rigorous requirements has been a dramatic drop in the reported incidence of measles, rubella, mumps, and whooping cough (pertussis) as shown in Figure 8-6. The incidence of some diseases continues to decline except for transient, temporary increases; the incidence of rubella and mumps had reached historic lows by the 1980s. The number of reported cases of each of these diseases is now well below one thousand annually.

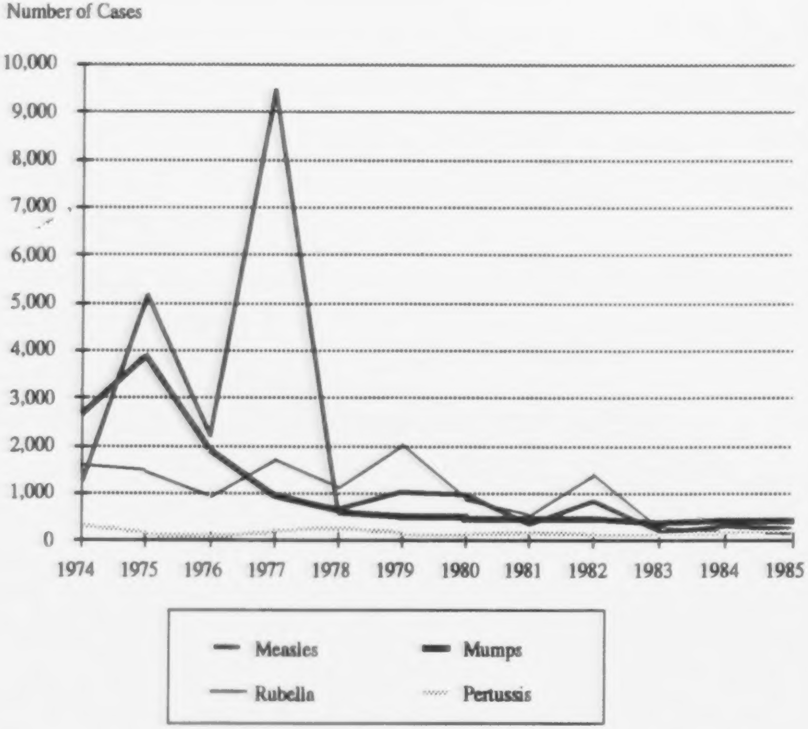
However, outbreaks can still occur. Los Angeles County in 1984, Riverside County in 1985, and San Bernardino and Sonoma counties in 1986 all experienced isolated outbreaks of measles. The 1986 outbreaks occurred in children ages 10 to 18. For the most part, however, rubella and measles tend to occur mostly among children below school age who are not enrolled in a child care center. Inadequately immunized young adults also can be stricken.

Even the low incidence of these illnesses can be reduced. But prevention is not easy.

Infections can be imported from abroad, children can be reported as vaccinated even though the vaccination was ineffective or not received at all, and many children are not vaccinated in a timely manner. Unless children are enrolled in a child care program, the immunizations often do not occur. Consequently, outbreaks of measles and rubella have been more difficult to eliminate than other diseases such as mumps and pertussis.

In spite of the general progress in immunizing more children, there continue to be groups of unprotected children. Nearly 60 percent of toddlers, for example, have not received the recommended immunization schedule of DTP (4+doses), polio (3+doses), and measles, mumps, and rubella, by their second birthday. Poorer children and minorities are more likely not to receive these immunizations. For example, a study of California children in 1985 showed that only one-fourth of black and Hispanic children were adequately immunized at 2 years of age.[29]

FIGURE 8-6 Reported Vaccine-Preventable Diseases in California



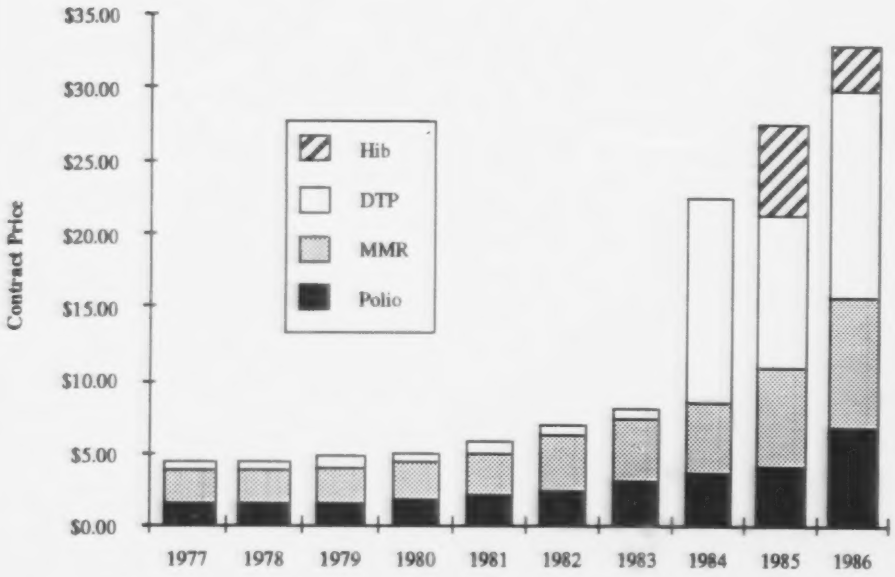
SOURCE: California Department of Health Services, Immunization Unit.

In addition to the vulnerable toddler population, residents of rural communities and densely populated urban areas continue to experience a greater than average risk of contracting infectious diseases. Chances for exposure are relatively greater in inner cities, and among any economically disadvantaged groups living in crowded conditions. Language and cultural barriers, particularly among new immigrants, also place children at greater risk for being unimmunized. In addition, these populations have less access to immunization services. Another important at-risk group is pregnant teenagers. Rubella is now striking teenagers who were not immunized in their childhood and who did not acquire immunity naturally. This group should receive special attention.[30]

The California Immunization Program was organized in the early 1960s. It organized the immunization efforts of the California Department of Health Services; local health departments; and other individuals, agencies, and organizations. The Immunization Unit of the Infectious Disease Branch, Disease Control Section of the California Department of Health Services, has primary responsibility for coordinating and administering the program.

In 1986 the federal government gave California $6.1 million for the program, and the state provided $3.3 million. A study by

FIGURE 8-7 Increases in Vaccine Costs to Immunize One Child



Note: Doses are 5 doses DTP, 4 doses OPV, and one dose of measles, mumps, and rubella vaccine. A CDC contract for purchase of DTP became available in April 1985.

SOURCE: California Department of Health Services, Immunization Unit.

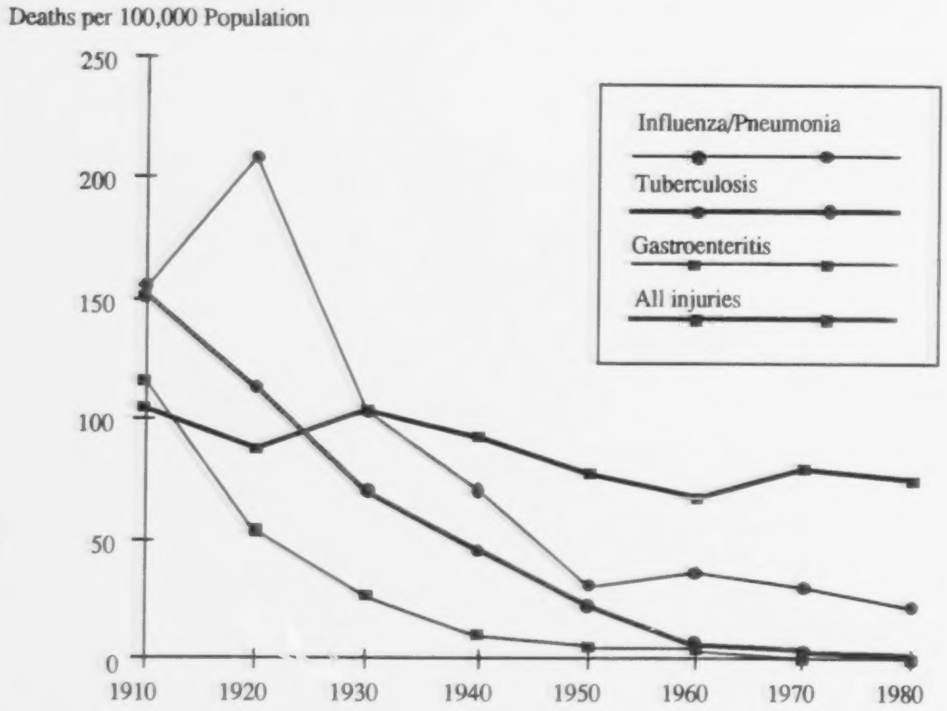
the federal Centers for Disease Control found that every dollar spent on measles vaccination saved about $10 in medical and long-term care by reducing the incidence of deafness, mental retardation, and other problems that result from measles.[31] Despite the clearly cost-effective nature of the program, there continue to be threats to its future success. Proposition 13, approved by voters in 1978, and the Gann Initiative's spending cap, have caused local health program budgets to be cut. The number of school nurses has been reduced, making enforcement of immunization requirements for school enrollment more difficult. Some county health departments have closed clinics, reduced operating hours, and generally narrowed the scope of many of their community outreach activities and services. Public immunization services do not reach as many people as they once did, threatening the vaccination program's steady progress.

The loss of state funds has caused some local health departments to begin charging fees ranging from $1 to $10 per visit for immunization services. Such charges, officials fear, deter families from seeking the immunizations their children need. To prevent the problem, officials from the state Immunization Unit have recommended that health departments limit such charges to $2 per vaccine dose or a maximum of $5 per family visit. A majority of health departments have adhered to these guidelines. But financial pressures have caused more local departments every year to charge in excess of the recommended fees.

To compound the problem, the cost of pediatric vaccines continues to escalate dramatically. In the past decade, the cost of completely immunizing a single child with publicly purchased vaccine has risen an astonishing 700 percent, from less than $5 to over $32 (Figure 8-7). This amount includes only the purchase price of the vaccine and not the immunization clinic's operating costs.

The main cause of this sharp rise in vaccine cost is manufacturers' price increases in response to skyrocketing liability insurance costs. Increases in state and federal funds, in response to these price hikes, have solved the problem temporarily. The

FIGURE 8-8 Death Rates from Injuries and Infectious Diseases, 1910 through 1980



SOURCE: S.P. Baker, B. O'Neill, and R.S. Karpf, *The Injury Fact Book* (Lexington, Massachusetts: D.C. Heath and Co., 1984).

liability issue, however, must be resolved nationally or price increases will continue.

The success of the California Immunization Program has meant that millions of California's children experience childhood without suffering from a variety of potentially debilitating diseases. The program has been one of the most effective prevention programs ever devised. But complete success will only occur when children younger than school age, the poor, new immigrants, and teenage mothers are all fully protected.

Causes of Childhood Mortality

Widespread immunization has dramatically reduced the occurrence of potentially disabling and discomforting childhood diseases. A variety of other public health measures has also largely eliminated what were formerly common causes of death among children after age 1. The range of child deaths that still occur include birth-related conditions, defects affecting one or several organ systems, genetic abnormalities, neoplasms, and some infectious diseases and injuries. Trends in cause-specific mortality rates can clarify the pattern of risks that children are exposed to and can indicate where programs need to be developed to reduce risk.

Death rates from common communicable diseases such as tuberculosis, gastroenteritis, and pneumonia have fallen by a hundredfold in the past fifty years as a result of antibiotics, sanitation, and other advances (Figure 8-8).

With the decrease in infectious disease, there has been a relative increase in the importance of injuries as a cause of death and disability. Accidental injuries are now the leading cause of death among all people between the ages of 1 and 24.

In the 1930s, deaths from infectious disease were eight times more prevalent than deaths resulting from accidental injuries to children in the 1-year-old to 4-year-old age group. By 1980, deaths caused by injuries equaled the number of deaths from all other causes for that age group. Injuries also accounted for 42 percent of the deaths among children ages 5 to 14 (Table 8-4).

Specifying the exact cause of death helps target programs aimed at prevention. Data show, for example, that although infants and children older than age 5 are most likely to die as occupants of motor vehicles involved in accidents, toddlers between the ages of 1 and 4 are most likely to be killed as pedestrians (Figures 8-9 and 8-10).

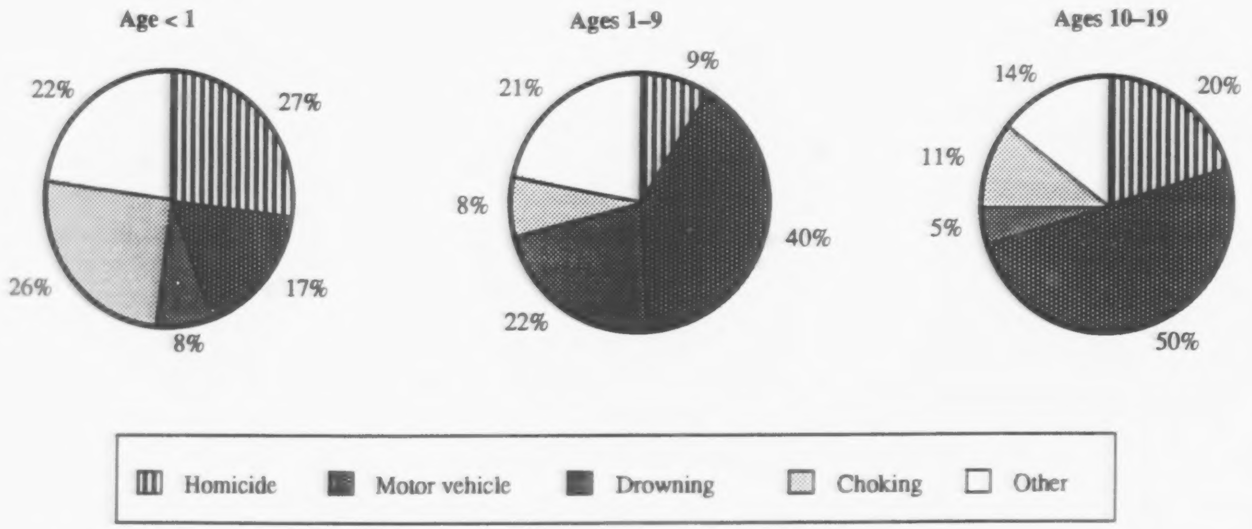
Deaths resulting from injuries do not strike all groups of children equally. Poor children, especially adolescents, are more

TABLE 8-4 Leading Causes of Childhood Death by Age, California, 1985

	Number	Percentage of Total
Before Age 1		
All Causes	4,475	100.0%
Perinatal complications	1,974	44.1
Congenital anomalies	1,059	23.7
Sudden Infant Death Syndrome (SIDS)	682	15.2
Unintentional injuries	109	2.4
Diseases of the heart	69	1.5
All other causes	562	12.6
Ages 1–4		
All Causes	885	100.0%
Unintentional injuries	370	41.8
Congenital anomalies	118	13.3
Malignant neoplasms	68	7.7
Homicide	38	4.3
Diseases of the heart	26	2.9
Meningitis	18	2.0
All other causes	247	28.0
Ages 5–14		
All Causes	888	100.0%
Unintentional injuries	374	42.1
Malignant neoplasms	152	17.1
Congenital anomalies	56	6.3
Homicide	48	5.4
Suicide	29	3.3
Diseases of the heart	21	2.4
All other causes	208	23.4
Ages 15–24		
All Causes	4,511	100.0%
Unintentional injuries	2,194	48.6
Homicide	794	17.6
Suicide	587	13.0
Malignant neoplasms	243	5.4
Diseases of the heart	105	0.8
All other causes	588	13.0

SOURCE: California Department of Health Services, Health Demography Section.

FIGURE 8-9 Injuries Causing Death, by Age, California, 1984

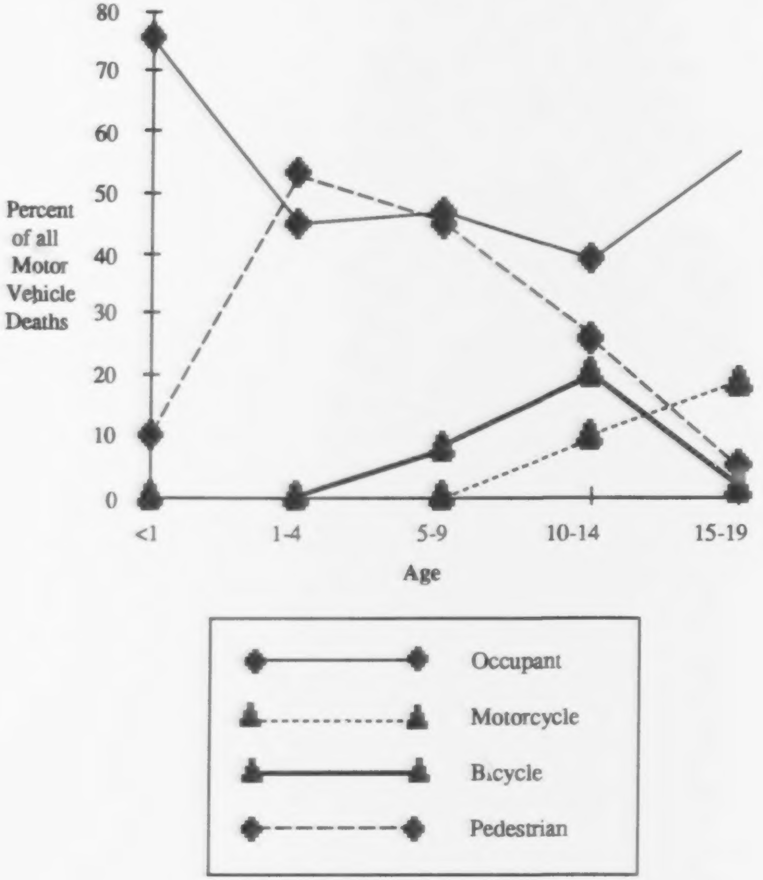


SOURCE: California Department of Health Services, Health Demography Section.

likely to be murdered than to die in motor vehicle accidents. The opposite is true for more affluent children. Boys are more likely than girls to die as the result of injuries, poisonings, and homicides. Knowledge of these income-, age-, and sex-specific mortality rates can be helpful in devising educational and preventive intervention strategies. Childhood injuries represent a serious and growing problem and demand a variety of interventions.

Better reporting of injuries is necessary to determine the true prevalence of fatal and nonfatal injuries. This will improve the accuracy of risk-factor analysis and enable the design of intervention programs that can be targeted at specific high-risk groups. It is known, for example, that children younger than age 6 are at risk for suffering non-sports-related falls, burns, and poisoning. Children ages 6 to 12 are at risk for motor vehicle and bicycle accidents. Young people between the ages of 13 and 19 are most likely to be injured in motor vehicle accidents and while participating in sports. Although interventions based on the risks experienced by the general population are advisable, specifically age-targeted programs would be useful as well.

FIGURE 8-10 Distribution of Deaths from Motor Vehicle Accidents, California, 1984



SOURCE: California Department of Health Services, Health Demography Section.

The legislative history of mandated safety belt use demonstrates that a specific legislative requirement can be effective in reducing injuries. Studies in several countries have demonstrated that legislation requiring the use of safety belts increases safety belt usage and reduces adult injuries in traffic accidents. A recent report by P. Agran and colleagues for the U.S. Department of Transportation found that the California Child Passenger Safety Act reduced the number of injuries suffered by children in Orange County, California. In their study, child restraint usage doubled from 26 percent to 50 percent as a result of the legislation. The report also showed a 16 percent drop in the number of significant traumatic head injuries resulting from motor vehicle accidents after the legislation became effective. The number of minor and moderate injuries suffered by children also dropped. These data indicate that deaths would have dropped as well, although the study did not address that issue.[32]

Programs that are similarly effective in reducing all manner of accidental deaths and injuries are needed.

Nutrition and Children in California

Providing children with an adequate diet has always concerned families, health and social service workers, and child advocates. This concern is based on a fundamental biological fact: people are more vulnerable to the effects of poor nutrition during the period from womb to adolescence than at any other time in their lives. Developmental success requires adequate nutrition. Lack of necessary nutrients can cause severe and permanent damage, far beyond what the same deficiency might cause in a fully developed adult. The health consequences of inadequate nutrition can be devastating, including low birth weight, infant mortality, lethargy, anemia, stunted growth, increased vulnerability to infection, and poor cognitive development.

In assessing nutritional problems, it is important to distinguish between malnutrition and hunger. The term *malnutrition* refers to either overnutrition or undernutrition. Overnutrition can cause obesity and predispose a person to diseases such as diabetes and coronary heart disease. Detection of malnutrition usually involves biochemical tests on blood and urine samples. Nationwide malnutrition data exist, but data on hunger in California do not.

Hunger is a subjective state. Antihunger activists believe that "no child should go to bed hungry." A more conservative definition of hunger might define it as prolonged nutritional deprivation that can lead to disease. The only data available for assessing the prevalence of hunger comes from local hunger surveys and trends in the use of emergency food services. No statewide surveys have been done on the prevalence of hunger in California. Some data do exist, however, on recent trends in use of soup kitchens and other emergency food services.

Most children do have access to adequate quantities of nutritional food, and do not go to bed hungry. But access is not enough: poor eating habits also can cause children to suffer from poor nutrition. Socioeconomic trends, such as the increase in two-worker families or the increase in the number of single-parent families in which the parent must work, have resulted in less adult meal planning. These trends have changed the diets of many children in dubious ways. Children today consume highly processed "fast food" much more than in the past. Foods that contain considerable quantities of fat, sugar, and salt, and scant amounts of fiber and nutrients, have become children's favorites. Such modern consumption patterns are related to common children nutrition problems such as overeating, obesity, and unbalanced diets, and place children at risk for hypertension, diabetes, heart diseases, and other nutrition-related degeneration diseases as adults.

Nutritional Status

This section focuses on the nutritional problems characteristic of children in poverty—the group most at risk for such problems. Many databases point to a growing problem of malnutrition and hunger—surveys of emergency food providers, studies of at-risk populations such as participants in the Special Supplemental Food for Women, Infants and Children (WIC) program, screenings done by the California Health Disabilities Prevention (CHDP) program, and data collected by civic groups.

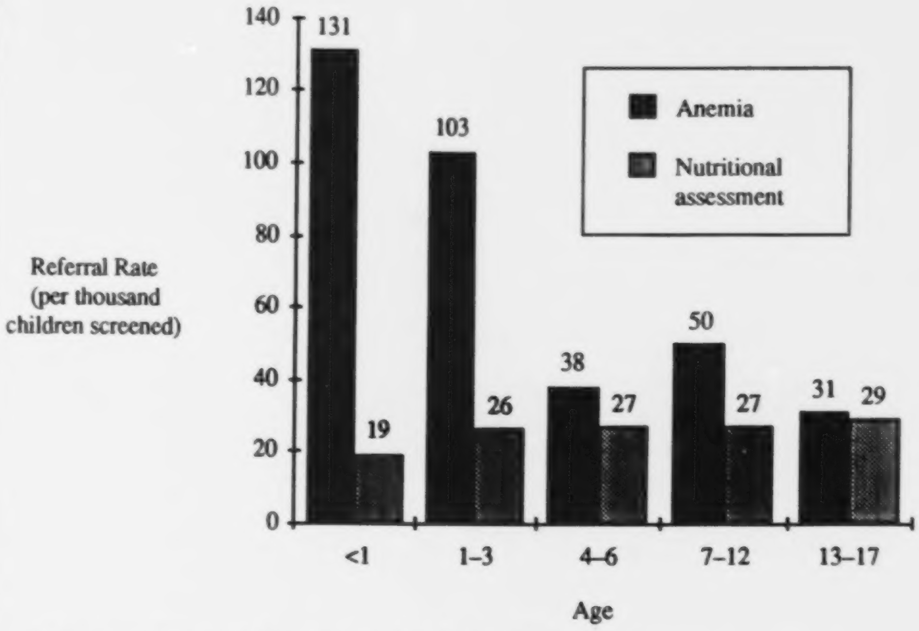
A conservative estimate of children's nutritional status can be extrapolated from data gathered by the CHDP. (Any estimate of statewide nutritional status using CHDP statistics is inherently conservative, for CHDP serves only a fraction of all poor children.) The CHDP program performs a set of comprehensive assessments of children's health, including a physical examination and some laboratory evaluations, such as a test for anemia. In addition, providers have the option of performing a nutritional assessment. This procedure consists of evaluating the adequacy of the child's diet as reported by the parents. The CHDP program then documents the number of children whose nutritional status places them at risk.

CHDP referral rates allow us to gauge roughly the prevalence of dietary problems and anemia in a high-risk population. However, these kinds of data must be treated cautiously, because nutritional assessments can be unreliable, self-reported dietary histories can be inaccurate, and physicians performing nutritional assessments have not had extensive nutritional assessment training (Figure 8-11).

In 1984–85, CHDP providers found anemia in 13.1 percent of infants screened, a much higher prevalence than among older children. Moreover, this percentage is twice the rate found in the 1976–80 National Health and Nutrition Examination Survey for infants living above the poverty level.[33] CHDP providers test for anemia because it usually indicates iron deficiency, a harmful condition stemming from poor nutrition.

When compared to 1981-82 referral rates, these numbers show that more children are being referred for anemia now than in the early 1980s. In the 7- to 12-year-old age group, the referral rate shot up by 50 percent. In both years, infants and toddlers had much greater anemia referral rates than older children.

FIGURE 8-11 CHDP Referrals for Nutritional Problems, by Age, California 1984–1985



SOURCE: California Child Health and Disability Prevention Program.

Nutrition Programs

Several federally sponsored programs offer nutritional assistance to the needy. California has consistently supported these programs, supplementing them with state funds, administering them, and backing them politically. But federal budget cuts launched with the Omnibus Reconciliation Act of 1981 (OBRA) have made the state's job tougher. The three largest programs—the Special Supplemental Food Program for Women, Infants, and Children; the National School Lunch and Breakfast Programs; and the Food Stamp Program—serve a combined total of more than two and a half million people, or approximately 10 percent of the state's population, each month. An examination of each of these programs, as well as privately run nutrition programs, provides a picture of the nature of hunger and malnutrition among California's children.

The Food Stamp Program. The federally administered Food Stamp Program, begun in 1964, provides monthly benefits to low-income households to help them buy food. The income-eligibility ceiling is 130 percent of the poverty level, based on specific asset levels and work requirements. AFDC households and those receiving Supplemental Security Income (SSI) automatically qualify. However, in 1982–83, only 80 percent of California's AFDC families actually received food stamps.[34]

In 1986, a family of four with no elderly or disabled member would have been eligible for food stamps in California if their gross income did not exceed $1,192 per month and the value of their cash and property did not exceed $2,000. This regulation particularly hurt the "new poor"—previously independent individuals and families whose income has dropped. They would not qualify for food stamps, for example, if they still owned a car or a house.

The program is designed to supplement a nutritious diet rather than provide for all food needs. The "thrifty food plan" (the diet on which food stamp allotments are based) was not intended to meet total nutritional needs. It was designed to provide a minimally adequate diet for a short period of time. Unfortunately, the limits inherent in the short-term plan have become a national norm.[35]

Anecdotal reports of families who run out of food before the end of the month are common. But these stories do not necessarily mean that these families do not plan or shop rationally and efficiently. In fact, studies have shown that poor families generally buy more nutritious food than those with higher incomes. Because they must shop more carefully, people with limited income often have learned to stretch limited supplies.[36] National surveys show that recipients generally spend the food stamps dollar sensibly across all food groups.[37]

Food stamp benefits have increased significantly relative to AFDC benefit levels since 1976, and they now play an even more important part in income support for poor families. The average food stamps payment increased from $937 to $1,364 between 1976 and 1984.[38] Yet this increase has not meant that food stamp benefits alone can provide any kind of adequate diet. In 1986, the average cash equivalent benefit per recipient in California was $33.07 a month, which is about 36 cents per meal per person.[39]

Increasingly, food stamps buy food for women and children. Several studies in California have reported that the proportion of food stamp households headed by women increased from 66.7 percent in 1982 to 71.1 percent in 1985. Almost half of the food stamp households in the state are headed by women with dependent children. In 1985, more than 60 percent of the members of participating households were under the age of 18.[40]

Nationally, the food stamp program reaches slightly more than half of the 33.4 million Americans living in poverty. Several estimates based on current poverty statistics indicate that, in California, the percentage of people eligible for, but not receiving, food stamps falls somewhere between 15 and 40 percent.[41] These numbers have grown since 1983, revealing a trend toward less participation in the Food Stamp Program as shown in Table 8-5. The table shows that total governmental expenditures on the Food Stamp Program declined steadily between 1983 and 1985, from $635 million in 1983 to $739 million in 1985.

The federal government has cut expenditures for the Food Stamp Program by reducing benefits and imposing stricter eligibility requirements. However, these budget cuts do not seem to have had quite the dramatic impact on the Food Stamp Program that they have on other programs, such as the Special Supplemental Food Program for Women, Infants, and Children, and the National School Lunch Program. Still, according to a 1985 study assessing the purchasing power of food stamps in eight major cities, the maximum food stamp allotment does not even cover the full cost of the "thrifty food plan." The actual cost of the plan for a family of four was $36.22 a month, while the food stamp allotment amounted to only $17.56.[42]

TABLE 8-5 The Food Stamp Program in California

	1980	1981	1982	1983	1984	1985
Participation (in millions)	1.5	1.6	1.7	1.8	1.7	1.6
Value of coupons (in millions)	$530	$604	$586	$739	$655	$640
Average benefit per person	$29.56	$31.37	$29.57	$34.48	$32.54	$33.02
Total cost (in millions)	$565	$646	$635	$796	$748	$739

SOURCE: Food and Nutrition Service, U.S. Department of Agriculture.

Four points should be considered in designing future food stamp policy:

- Many people rely on food stamps as their permanent main source of nutrition, yet the "thrifty food plan" was designed only as a short-term solution.
- Benefits levels do not keep pace with the actual cost of food.
- Because benefits do not last until the end of the month and the program makes no provision for emergency relief, emergency food providers bear the heavy burden of picking up where food stamps leave off.
- Because of barriers such as inadequate outreach and overly complicated applications, many eligible children do not receive food stamps at all

The Special Supplemental Food Program for Women, Infants and Children (WIC). The Special Supplemental Food Program for Women, Infants, and Children, or WIC, began as a pilot project in 1972 and now operates as a grant program administered by the Food and Nutrition Service of the U.S. Department of Agriculture (USDA). Local health agencies and clinics provide benefits, in the form of supplemental foods and nutrition education, to low-income pregnant, postpartum, and lactating women, as well as low-income infants and young children up to age 5 who are found to be at nutritional risk.

To be eligible, an individual's income must be below 185 percent of the state poverty level. In addition, some applicants must demonstrate nutritional risk. All infants and pregnant and lactating women are eligible regardless of medical risk, because of their special nutritional needs. But children and nonbreastfeeding postpartum women must show evidence of medical problems that can be helped by an improved diet. Such problems might include obesity, underweight, stunted growth, anemia, serious food allergies, severe dental decay, diabetes, or renal disease. Women can qualify if they have a history of high-risk pregnancies, or an inadequate dietary pattern.

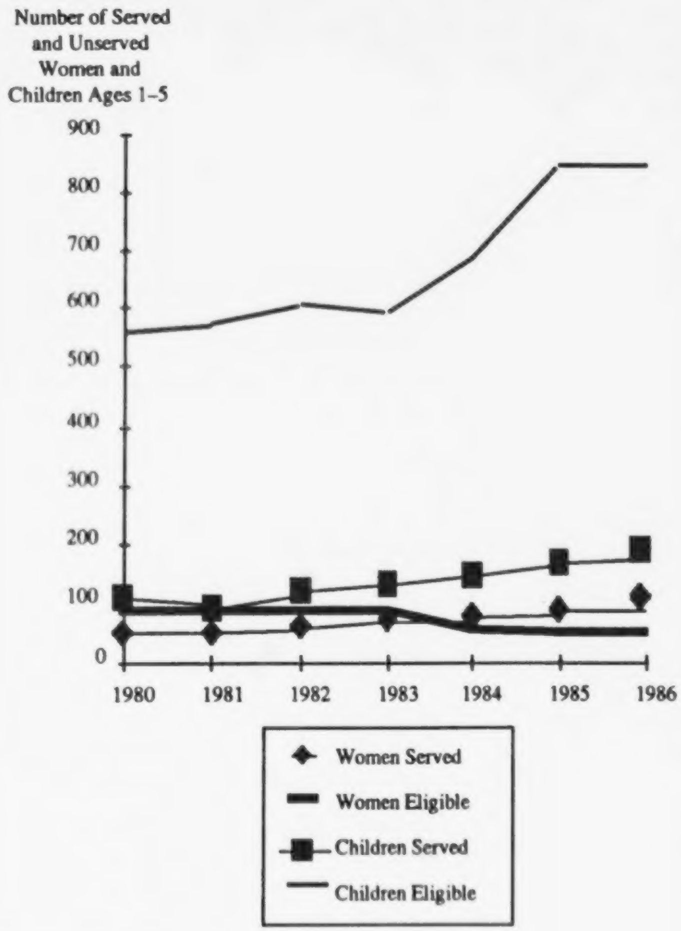
WIC participants receive a nutritional assessment, education, referrals to medical care providers, and information on other assistance such as food stamps and Medicaid. Pregnant women are required to begin prenatal care if they have not done so already. The primary reason women seek WIC services, however, is to help them feed their families. They receive vouchers once a month for such items as iron-fortified infant formula, cereal, juice, eggs, and dairy products, all of which are high in protein, calcium, iron, and vitamins A and C.

The WIC program has proven extremely beneficial to the health of its participants. The 1984 National WIC Evaluation found that WIC enrollees had babies with substantially higher birth weights than mothers not receiving WIC services. Also, WIC mothers had improved diets.[43] Evaluators have also demonstrated the cost-effectiveness of the WIC program. The most commonly cited statistic, from a Massachusetts study, is that every dollar spent by WIC reduces hospital expenses by three dollars.[44]

In 1984 California ranked forty-fifth among the states in the percentage of WIC-eligible clients served. Presently, only 22 to 25 percent of people in California who are income-eligible actually receive WIC benefits. Because the demand for WIC services so greatly exceeds availability of funds, food, and staff, federally set priorities are used to decide who is served. Hard choices have been made. In particular, program officials must choose between making sure that expectant mothers eat properly so that they can bear healthy babies, and ensuring the health of children already born. Currently, pregnant women, breastfeeding mothers, and babies take priority (Figure 8-12). Approximately one million children lose badly needed assistance when they reach the age of 18 months.

The decision to put infants and pregnant women first is justifiable, in light of their greater risk from nutritional deficiency. Ensuring that babies are well fed before and after birth prevents later problems. Moreover, evidence suggests that concern is warranted: in an evaluation of WIC recipients entering the program in San Mateo County, the diets of pregnant and lactating women were poorer on the whole than the diets of infants and children. But this policy choice has meant that many children who need supplemental food do not receive it. The number of pregnant women who were eligible because of income but did not receive WIC

FIGURE 8-12 WIC Participation, Those Served Versus Those Eligible But Not Served, California, 1980–1986 (in thousands)



SOURCE: California Department of Health Services, WIC Office.

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services was cut in half between 1980 and 1985; during that same period the number of unserved children and infants rose from 559,556 to 838,198.

Migrant farmworkers use 3.4 percent of the state's WIC resources. Often the members of this group are unaware of the program, and their access to its services is limited. Also, many fear deportation and find policies for immigrant eligibility unclear. As a result, only 5 percent of the estimated 200,000 migrant women and children have any contact with the WIC program.[45] Yet, this population is especially needy. The unmet need is exacerbated by the fact that this population resides in rural areas, which often lack the infrastructure necessary to organize and provide access to food assistance.

The federal expenditure for California's WIC program has risen steadily since the program began. In 1987, federal funds totaled $149 million, 83 percent of which was spent on food, while the remaining $25 million covered administration costs.[46]

The main problem with the WIC program is that benefits are frequently delayed and denied. Long waiting lists and long waiting periods before eligibility is determined, as well as a lack of outreach, mean that women often do not receive nutritional assistance until late in their pregnancy. For example, in Imperial County the waiting time is from four to six months.[47] Already-vulnerable youngsters may not receive benefits when they most need them. Benefits are denied to children because of federal priorities. Once infants reach the age of 18 months, they face a long period of ineligibility for other nutritional assistance programs. Not until they reach kindergarten do they again receive any supplemental food assistance.

National School Breakfast and Lunch Programs. Children fare better nutritionally once they reach school age because of the National School Breakfast and Lunch Programs. The connection between hunger and educational performance were established in 1946 when school food programs began. Since then, a subsidized lunch for those who need it has been part of the promise of daily life at school. But in the 1980s federal budget cuts have caused some schools to drop the program or begin charging students more to participate in it. The result has been a period of increasing poverty and hunger. It appears that the federal government may have reneged on its promise.

One of the most effective federal nutritional assistance programs, the school lunch program reaches a fairly high percentage of eligible low-income children. The program offers at least one hot meal a day to 65 percent of all public school children nationwide, and feeds 1.4 million of California's children daily.[48] The National School Breakfast Program, initiated in 1964, enables some children to have two hot meals per day. More than 7,000 California schools participated in the school lunch program in 1986, while fewer (about 2,500) provided school breakfasts.[49]

Support for the school breakfast and school lunch programs comes from the USDA Food and Nutrition Service. In addition to per-meal subsidies, the USDA donates commodity foods to participating schools. State and local funds and children's payments (up to approximately 30 cents for a reduced-price meal in 1985–86) also help finance the cost of the program. Students may receive free meals if their family income falls below 130 percent of the poverty line. Students from families whose income is between 130 precent and 185 percent of the poverty guidelines may purchase meals at reduced prices. All other students pay full price.

Even full-price payment is a good deal. The National Evaluation of School Nutrition Programs estimated that in 1983 the typical high school lunch provided by the program cost $1.10. Purchased at a grocery store and prepared at home, the ingredients of the meal would cost $1.50. A comparable lunch at a fast food outlet would cost almost three times as much, require students to leave campus, and have less nutritional value. The study concluded that buying a school lunch or breakfast made sense both economically and nutritionally. The study found that such meals provided one-third of the Recommended Dietary Allowance (RDA) of daily nutrients, and that students who eat school meals receive better nourishment than those whose meals come from other sources.[50]

Although California's schools must feed increasing numbers of hungry children, their capacity to do so has diminished (Table 8-6). Schools served fewer meals to students in 1985 than they did in 1981. In particular, budget cuts have targeted children who pay the full or reduced price for school meals; in comparison to 1980, 14 to 23 percent fewer lunches and 34 to 52 percent fewer breakfasts were served in 1985 to students paying the full or reduced price.

The 1981 federal budget cuts restricted income eligibility guidelines for free and reduced-price meals and reduced the average payment to schools for meals served. The program's budget has experienced steady incremental increases (smaller in the breakfast than the lunch programs) since then. But rising food costs have meant that the same amount of money simply did not buy as many meals in 1985 as in 1980. Moreover, federal subsidies have not kept pace with inflation or with the increasing numbers of school-age children, many of whom depend on a school breakfast or lunch for their only nutritionally balanced meal of the day.

Declining participation in the National School Lunch Program has been the end result of programmatic changes resulting from federal budget cuts. Many schools have been forced to drop the program completely. Some schools in low- and moderate-income areas are forced to either pass the cost on to their students or stop offering meals altogether. Individual families have dropped out of the program due to stricter eligiblity guidelines or because of higher meal prices. Finally, many families never become eligible at all because of the increasingly rigorous application process.[51]

Emergency Food Providers. Historically, emergency food services have taken various temporary forms, for example, soup kitchens and bread lines in the Depression era. Agencies providing emergency food services simply are not set up to provide more than short-term crisis relief. Yet today they are being forced to supply permanent sustenance for certain groups of people, including a rapidly growing number of children.

TABLE 8-6 School Breakfast and Lunch Programs in California, Program Costs and Number of Meals Served (numbers and dollars in millions), 1980–1985

	1980	1981	1982	1983	1984	1985
Average Daily Meals	2.2	2.3	2.0	2.0	2.0	2.1
Meals Served						
Free	226.8	245.8	233.6	242.9	247.2	253.6
Reduced price	28.8	29.5	24.6	23.9	23.9	25.6
Paid	144.2	132.6	100.2	98.8	105.5	119.1
Total	399.8	407.9	358.4	367.6	378.6	400.4
Total Cost	$305.3	$341.7	$314.0	$343.3	$376.0	$388.5

SOURCE: Food and Nutrition Service, U.S. Department of Agriculture.

Such a situation seems incongruous with the existence of enormous federal nutrition programs such as WIC, the Food Stamp Program, and the National School Lunch Program, and income maintenance welfare programs such as AFDC. Despite the services provided by those programs, there is a resurgence of hunger in California. Any church or community-based emergency food provider can attest to the fact that more people need their services than ever before.

Data on emergency food providers come from various local surveys. They are not comparable, nor are they necessarily statistically valid or reliable. Rather, they allow us to observe general trends and gain a sense of the extent of hunger and the demand being placed on these emergency providers.

During the past five years, many new emergency food providers have sprouted up all over California. Such organizations have experienced steadily increasing demand for their services. Hunger Watch U.S.A., a hunger-monitoring system based in Washington, D.C., and overseen by Bread for the World Education Fund, estimated that the nation's need for emergency food services increased 16 percent between 1984 and 1985.[52] In California, Los Angeles County's 300 food pantries saw more than a 50 percent annual increase in demand for their services from 1983 to 1984.[53] The San Francisco Food Bank distributed approximately 20,000 pounds of food per month during 1982-83; during 1985-86 that figure reached 200,000 pounds per month.[54]

The types of people lining up for emergency food assistance has changed in the past decade. No longer are breadlines made up primarily of single, adult, transient males. A *Sacramento Bee* (newspaper) report, which included a survey of all major food banks in California, estimated that of the 2.3 million Californians seeking emergency food every month, almost half are children.[55] The trend in San Francisco is similar: 85 percent of the 17,154 individuals who received food boxes from the Emergency Food Box Program were women and children.[56]

In Santa Clara County, rising housing costs and unemployment mean that those seeking emergency food often are members of the "new poor." In addition, emergency food providers are seeing more and more people whose food stamps have run out or are delayed, or people who were dropped from the program when eligibility guidelines became more restrictive.[57]

When asked, emergency food recipients surveyed in various locations across California gave similar reasons for seeking food assistance; recent or chronic unemployment, low pay, and insufficient assistance from other government programs were the most common answers. Approximately one-third of those asked said it was their first time seeking food at that site.[58]

The *Sacramento Bee* survey estimated that more than 2,800 food pantries and distribution sites attempt to feed 2.3 million hungry Californians. These sites are usually operated by volunteers from private religious and community organizations. Many of these providers have reached their limit of the number of people they can help. Many, because of limited funds, staff, and food, have had to cut back on hours and restrict eligibility. According to the main food bank in Alameda County, food providers in Oakland turn away as many as 3,600 hungry people each day.[59]

Charitable organizations have always jumped in to help feed the hungry when the need is great. In the 1980s, many of these providers have reached their limit on the amount of help they can give, yet the need continues to rise. The government must decide if, in light of the overwhelming need, it will make this private effort more successful, through financial support and coordination of services.

The services of every existent nutrition program are limited. As noted, WIC ends its assistance when babies reach 18 months of age. We have also noted that the "thrifty food plan," on which the Food Stamp Program is based, is designed only for short-term and inadequate sustenance. Emergency food providers have never considered themselves more than temporary relief. And school

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nutrition programs can only reach children in those schools that participate and only when schools are in session.

In the area of nutrition, the basic policy question is whether the network of public and private food assistance programs works well enough to provide adequate nutrition to all vulnerable children in California. Although more data are needed, it seems clear that the vast majority of the needy are not being adequately served. Should improvement efforts concentrate on increasing the benefits and the numbers of children served? Or should programs be redesigned so that each is targeted toward a specific need or population, and so that together they can provide adequate nutritional assistance to all who need it?

These and other policy questions will remain until more and better data are available on the adequacy of current services and the real extent of nutritional needs. Policymakers seeking to improve children's nutrition should push for statewide collection of this information. But waiting for all the data to be collected may mean waiting too long.

The Health of Adolescents

Adolescence is a time of transition, of increasing independence and choices. The duration of this transition has depended on social, cultural, and historical influences. The beginning of adolescence is usually heralded by expected biological changes in the individual, and the end of adolescence is often determined by socioeconomic factors— a full-time job, marriage, or having a baby.[60] Although adolescents usually evoke an image of vitality and strength, adolescents suffer from increasing rates of sexually transmitted diseases, alcoholism, and drug abuse, and must face an array of behavior choices that will have consequences for their adult years.

Adolescents are the one group in U.S. society that is experiencing an increasing mortality rate. And the deaths do not result from a new infectious disease. Rather, the rising mortality rate results from violence. Injuries, homicides, and suicides are now the top three causes of deaths among young people aged 15 to 24. Especially shocking is the homicide rate for nonwhite men, rates that are so high that almost one out of every one hundred black youngsters who turns 15 becomes a homicide victim before the age of 25.[61]

As with younger children, adolescents have nutritional problems related to poverty as well as to the lack of a structured home environment. But with adolescence comes new problems. Adolescents often lose interest in all physical activity and suffer from a variety of maladies resulting from lack of vigorous physical exercise. And, furthermore, they begin engaging in dangerous behaviors, such as drug and alcohol abuse and unprotected sexual intercourse.

Recent studies done in school-based clinics found that medical and mental problems were prevalent among adolescents.[62] The frequency of these problems is demonstrated by health assessments given by the California Health Disabilities Prevention program (CHDP). In 1981–82, 59 percent of the teenagers who were screened through CHDP providers were referred for further diagnosis and treatment (Table 8-7 and Figure 8-13). This is the highest referral percentage of any age group assessed by the program. But it may reveal only a portion of the degree of need among poor adolescents because program guidelines allow only one routine medical visit every three years.

The purpose of the CHDP program is to identify presymptomatic conditions before they cause symptoms of serious health problems. But the limits placed on visits by adolescents prevents the program from achieving its purposes. It is during adolescence that many young people begin having problems with depression, contemplation of suicide, adolescent pregnancy, and many forms of antisocial behavior. Adolescence should be one of the periods in young lives on which programs such as the CHDP focus their prevention efforts. Developing new initiatives to deal with the challenge of the adolescent age group is one of the most

TABLE 8-7 Number and Percent of Teenagers Referred by CHDP Health Assessments for Diagnosis and Treatment, by Health Assessment Procedure, Fiscal Year 1981–82

	Ages 13–17 (28,691 individuals)		Ages 18–20 (6,090 individuals)	
	Number	Percent	Number	Percent
All Procedures	16,391	57.1%	4,125	67.7%
History and physical	9,660	33.7	2,799	46.0
Immunizations	7,740	27.0	2,020	33.2
Dental	1,810	6.3	465	7.6
Hemoglobin/hematocrit	630	2.2	182	3.0
Nutrition	797	2.8	199	3.3
Vision	1,248	4.4	261	4.3
Hearing	516	1.8	116	1.9
Urine	599	2.1	120	2.0
TB	536	1.9	201	3.3

Note: Number referred for diagnosis and treatment as a percent of all individuals given health assessments: based on MediCal-funded fee-for-service health assessments that included a history and physical examination. Some individuals were referred for more than one problem area so the individual problem areas do not sum to the total of "all procedures."

SOURCE: California Department of Health Services, CHDP Program.

pressing prevention problems facing health providers today. Even if adolescents were more adequately served by CHDP, other needed resources, for example, counseling and mental health services and drug treatment programs, would still be limited.

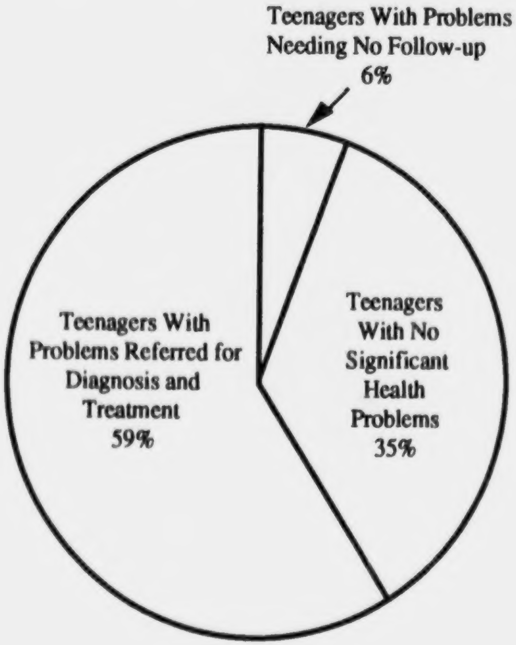
Drugs, Alcohol, and Smoking

Adolescence is a time of testing limits as children try out the experience of being independent from their parents. It is a time during which they put themselves into situations in which they are forced to make important decisions—such as how much risk it is reasonable to take—that they are not always ready to make wisely.

There are several elements in determining whether a young person is "at risk," a term many educators and other youth workers and professionals use to signify that someone is headed for trouble. A teenager who smokes marijuana regularly or smokes crack cocaine every few days or gets drunk every weekend is compromising his or her ability to become a responsible adult. Depending on which drug is used, it could be said that between 10 and 25 percent of the teenage population has a drug problem. A much greater number of young people has experimented with illicit drugs. Although no drug use at all is the preferred behavior, a distinction must be made between the curiosity of a healthy teenager and the troubled spirit that leads to substance abuse and addiction.

On several fronts, trends in teenage drug and alcohol use and smoking are encouraging. The 1987–88 survey of drug and alcohol use among California students found that the percentage of seventh-, ninth-, and eleventh-grade students who had used

FIGURE 8-13 Percent of Teenagers (Ages 13–20) Given CHDP Health Assessments Who Were Referred for Diagnosis and Treatment, All Teenagers Examined, Fiscal Year 1981–82



Note: Based on MediCal-funded fee-for-service health assessments only. Percentages are based on 34,781 health assessments that included a history and physical examination.

SOURCE: California Department of Health Services, CHDP Program.

those substances had declined—in some cases precipitously—since a survey two years earlier. However, the percentages are still quite high. For example, 42.4 percent of eleventh-graders said they had tried illegal drugs by the time they were 16 years old, a steep drop from two years earlier, when 51.4 percent of the eleventh-graders questioned said they had tried illicit drugs.[63] An even higher percentage, 61.5 percent, of the eleventh-graders said they had been intoxicated with alcohol at least once by age 16. Two years earlier 65.2 percent of the students responded that they had been drunk at least once.

Actually, the use of alcohol and other drugs begins much earlier than age 16. Nearly half of 11-year-olds (45.8 percent) said they had tried alcohol, and 10 percent reported that they had gotten drunk. Almost 15 percent of seventh-graders reported having first gotten drunk at age 12. Nine percent of seventh-graders said they had tried illegal drugs, while 23.4 percent of ninth-graders said they had tried drugs.

Regarding cigarette smoking, the numbers are more encouraging. Nearly three quarters of the eleventh-graders (73.3 percent) said they had never smoked a cigarette, compared to 69.2 percent just two years ealier. Moreover, only 3.6 percent of eleventh-graders reported smoking more than 11 cigarettes a day. Smoking has also been identified by epidemiological researchers as a precursor to drug and alcohol use.[64] Unlike the figures for the use of other drugs and alcohol, however, the percentage of students who smoke does not increase as they get older.

Use of almost all drugs by high school seniors has declined nationwide, with usage having peaked for marijuana in 1978, for PCP in 1979, for LSD in 1980, for amphetamines in 1982, and for cocaine beginning in 1987. In 1987, cocaine use declined by one-fifth from the previous year (from 12.7 to 10.3 percent). The impact of the recently emerging use of the highly addictive crack-cocaine is yet to be determined.

In addition, young people are far more likely now than they were ten years ago to think that drugs and alcohol are potentially harmful. For example, the percentage of high school seniors who have tried marijuana and who nonetheless think it involves taking a "great risk" doubled from 9.5 percent to 18.4 percent between 1977 and 1987.[65] Nearly 90 percent of the seniors who used cocaine thought it involved taking great risk.

However, fears about the potential harmfulness of drugs do not always get expressed among peers, especially as intense pressures to conform weigh heavily. More than 80 percent of California eleventh-graders questioned said they would either tolerate or join in with a friend who drinks alcohol and gets drunk.[66] More than 60 percent responded in the same way when asked about getting high on drugs.

Society expresses concern about the use of drugs and alcohol and other dangerous substances by youth because of the fear that they will damage themselves and be unable to reach adulthood with their health and faculties intact. But designing policies to address the issue is difficult. There are already legal and, to a lesser extent, moral prohibitions against substance abuse by young people. But these prohibitions have not by any means prevented substance abuse from becoming a problem. Education, while it may not prevent young people from engaging in harmful drug and alcohol usage, may help them make better informed choices in this area.

There is some evidence that existing educational programs are effective in getting their message across. The 1988 survey of students found that 63.1 percent of eleventh-graders said they had learned in classes at school that drugs and alcohol could be harmful. Nearly 50 percent of the eleventh-graders surveyed said the classes helped them avoid or reduce their alcohol or drug consumption. Less than 10 percent of the students said they were unaffected or that they had learned nothing in the classes.

Irrespective of the hopeful trend reflected in this most recent survey, additional creative interventions must be explored to address the use of drugs, especially in poor and minority communities. Although overall trends in drug use for the entire population of youth may be diminishing, for some adolescents, confronted with school failure, unsupportive home environments, and a perception of few life options, use of drugs and substances becomes an all-too-attractive alternative.

Adolescent Pregnancy and Parenting

Adolescent sexuality and pregnancy, always a feature of U.S. life, has not traditionally been a matter of public policy. What has brought this issue to the forefront is the fact that rates of adolescent sexual activity, pregnancy, and out-of-wedlock childbearing have risen significantly in the past twenty years.

Although specific data on the number of sexually active adolescents living in California do not exist, national data based on randomly selected adolescents showed that between 1971 and 1982, the percentage of never-married females aged 15 to 19 who lived in metropolitan areas and had already had sexual intercourse rose from 28 to 42 percent.[67] The pregnancy rate in California among young women aged 13 to 19 increased in the late 1970s (54.4 per thousand in 1979), decreased in the early 1980s (50.5 per thousand in 1982), and then, according to the most recently available data, rose again in 1985 (to 54.4 per thousand).

California has the second highest adolescent pregnancy rate in the nation. Early parenthood has negative effects on the education, future employment, and health of the mother as well as the child. The complex social and medical aspects of this issue have spurred policies that attempt a variety of interventions. But the tremendous developmental, cultural, and demographic diversity of the adolescent population requires additional approaches.

Incidence of Adolescent Pregnancy in California

In 1986, a total of 52,718 babies were born to mothers under the age of 21. Of these, 901 were born to girls under the age 15, 18,354 to adolescents aged 15 to 17, and 33,463 to young women aged 18 to 19. Nearly 60 percent of the teenage mothers were not married at the time of delivery. Of the girls younger than age 18, nearly 75 percent were unmarried. Nearly 11 percent of all births in California in 1986 were to adolescents. The adolescent birth rate was 53.2 per thousand, ranking California twenty-sixth in the nation in this regard. However, the state's overall adolescent pregnancy age was 142.7 per thousand, substantially higher than the national rate of 109 per thousand. That statistic ranks California second in the nation. Counties vary widely not only in the number of babies born to adolescents, but also in teenage birth rates. In 1986, the age-specific live birth rates ranged from 8.8 per thousand in Marin County to 91.7 per thousand in Tulare County for this age group (Table 8-8).

Adolescent birth rates vary among racial and ethnic groups. In California, Hispanics and blacks have a higher percentage of births to adolescents (15 and 19 percent, respectively) than do non-Hispanic whites (8 percent) (Table 8-9). By comparison, the overall percentage of births to teenagers in the state for 1985 was 11 percent (Table 8-10). In that year, 44 percent of births to mothers under the age of 20 were to Hispanics, 35 percent were to whites, 15 percent were to blacks, and 6 percent were to other ethnic groups. This means that the proportion of Hispanic and black teenage births is much higher than the proportion of these two groups in the total California population (which is 62 percent white, 22 percent Hispanic, 9 percent black, and 9 percent Asian.[68]

The large differences in birth rates according to race and ethnicity and the birthrate trends in recent years signal a need for policies that are sensitive to the major demographic changes occurring in California. The state's population, increasingly, is made up of residents who are poorer and younger than before. In addition, the proportion of the state's population that is Hispanic is on the rise. Because Hispanics, the poor, and the young have higher-than-average birthrates, the time to begin shaping these policies is now.

The adolescent birthrate will most likely increase unless or until abstinence becomes a more accepted behavior or more and better means of contraception are used by sexually active adolescents. The birthrate is increasing not only among Hispanics but also among white adolescents. This increase is occurring among the affluent as well as among the poor and the poorly educated.[69] Numerically, the bulk of these at-risk adolescents will continue to be white and Hispanic adolescents. Therefore, family life education programs and reproductive health services should be planned with all of California's highest-risk adolescents in mind. In part this means that these services, particularly those programs aimed at reaching the Hispanic community, will have to be culturally and linguistically appropriate for California's diverse ethnic population. Part of any comprehensive strategy for reducing unwanted pregnancy will be programs effective in keeping students, especially poor students, in school. This approach would help increase this vulnerable population's perception that other options are available.

Medical Issues

Recent evidence indicates that adolescence need not increase the risk of poor outcomes for pregnancy and birth. But risk factors other than age— such as poor prenatal care and poverty— do cause adolescents to have poorer pregnancy and birth outcomes, and adolescent mothers are more likely than older women to be affected by these risk factors. Adolescents are more likely to experience pregnancy-induced hypertension, anemia, and births by caesarean section. Many low-income, pregnant adolescents qualify for MediCal services and thus face the difficulty of finding a doctor willing to accept MediCal reimbursement. Even when prenatal

TABLE 8-8 Age-Specific Live Birth Rates, by California Counties and Age of Mother, 1985

Place of Residence	10–14	15	16	17	18	19	15–19
CALIFORNIA	**1.0**	**13.1**	**30.1**	**51.9**	**71.2**	**93.2**	**52.5**
Alameda	1.3	10.6	24.1	33.7	49.2	64.4	37.4
Alpine	—	—	—	—	—	a	a
Amador	—	—	a	a	49.3	109.5	36.3
Butte	1.5	9.7	34.2	48.6	41.6	58.9	41.5
Calaveras	—	a	a	43.5	56.7	82.1	38.4
Colusa	—	a	a	a	117.6	112.4	56.3
Contra Costa	1.1	9.3	18.3	32.9	55.5	63.5	34.6
Del Norte	a	a	a	47.6	156.5	111.9	69.0
El Dorado	a	8.2	19.8	31.7	69.5	77.3	40.0
Fresno	1.6	23.8	49.4	85.0	96.7	121.7	77.3
Glenn	a	—	a	75.0	63.7	170.4	61.3
Humboldt	a	6.8	21.9	42.6	52.5	60.6	39.8
Imperial	a	14.5	37.2	66.7	90.4	115.8	64.9
Inyo	a	—	a	a	a	64.0	27.2
Kern	1.9	21.7	52.1	87.2	128.5	159.6	89.4
Kings	1.8	36.2	40.4	59.2	121.9	219.7	92.5
Lake	a	14.3	46.6	60.5	107.7	133.8	70.4
Lassen	—	a	a	68.0	71.0	109.9	53.4
Los Angeles	1.3	16.3	37.0	64.8	87.1	113.4	63.8
Madera	1.9	14.7	50.0	85.0	110.4	119.2	74.9
Marin	—	—	4.2	9.3	14.0	27.8	9.9
Mariposa	—	—	a	a	a	85.7	32.5
Mendocino	—	12.2	28.2	49.3	75.3	136.3	57.1
Merced	1.1	28.8	48.1	73.2	146.9	153.7	88.1
Modoc	a	a	—	a	a	76.9	35.0
Mono	—	—	a	—	a	196.1	50.9
Monterey	0.8	14.9	29.1	62.8	84.5	93.3	58.1
Napa	a	a	11.0	27.5	38.8	63.0	29.8
Nevada	—	a	12.9	27.0	43.9	65.0	29.6
Orange	0.6	7.9	20.1	33.9	50.5	72.6	37.4
Placer	a	a	20.5	32.6	52.6	66.2	34.6

(TABLE 8-8 continued on next page.)

TABLE 8-8 Continued

Place of Residence	10–14	15	16	17	18	19	15–19
Plumas	—	a	a	a	55.1	79.4	33.8
Riverside	0.9	14.7	37.7	64.4	82.1	108.9	61.4
Sacramento	1.4	14.6	35.3	56.9	70.5	98.8	55.7
San Benito	a	a	30.5	50.4	87.9	81.5	52.1
San Bernardino	1.2	12.7	35.7	62.8	94.5	112.2	63.0
San Diego	0.7	9.0	23.4	40.7	56.2	81.5	44.0
San Francisco	1.2	12.8	26.9	42.3	56.4	63.6	41.5
San Joaquin	1.7	23.6	40.7	67.9	98.8	125.7	72.0
San Luis Obispo	a	13.7	14.3	36.3	33.9	38.6	29.1
San Mateo	a	4.2	13.9	23.0	45.6	53.5	27.1
Santa Barbara	0.8	8.1	19.7	30.3	33.5	51.5	31.5
Santa Clara	0.6	9.8	21.0	36.8	50.4	65.6	37.2
Santa Cruz	1.3	9.4	23.9	45.9	49.0	81.8	43.2
Shasta	a	11.7	24.7	62.8	76.8	85.3	52.1
Sierra	—	a	—	a	a	a	49.0
Siskiyou	—	16.0	31.1	35.0	65.7	67.1	42.7
Solano	a	12.8	17.9	38.2	73.1	97.1	47.5
Sonoma	a	7.4	12.1	28.5	44.1	65.1	31.0
Stanislaus	1.6	17.5	41.0	52.3	96.0	122.1	64.9
Sutter	a	16.7	23.8	65.4	83.3	121.7	63.2
Tehama	—	a	15.2	50.5	80.3	96.5	49.6
Trinity	—	a	a	64.1	a	62.5	45.5
Tulare	1.9	23.7	47.3	84.1	108.1	160.5	83.7
Tuolumne	—	a	a	43.3	24.2	98.3	37.0
Ventura	0.7	8.8	24.0	37.0	66.6	81.7	42.6
Yolo	a	13.4	31.7	51.8	24.4	42.3	33.1
Yuba	a	12.2	68.1	106.6	100.3	107.8	76.6

[a] Rates not calculated for fewer than five live births.

Note: An age-specific live birth rate is the number of live births per 1,000 women in a specific age group. For women under 15, the rate is calculated using the female population 10–14 years of age.

SOURCE: California Department of Finance. California Department of Health Services.

TABLE 8-9 Live Births by Race/Ethnicity and Mother's Age, California, 1985

	Age of Mother											
	10	11	12	13	14	15	16	17	18	19	10-19 Total	Percentage of Births
Hispanic	0	1	8	67	338	1,177	2,624	4,139	5,978	7,849	22,181	15.1%
White	0	0	0	15	161	709	1,794	3,246	5,150	7,692	18,767	8.0
Black	0	1	8	40	196	530	941	1,420	1,930	2,510	7,576	18.8
Asian	0	0	0	3	25	57	118	197	321	395	1,116	4.2
All others	0	0	0	6	21	81	153	321	445	588	1,615	7.3
Total	0	2	16	131	741	2,554	5,630	9,323	13,824	19,034	51,255	10.9

SOURCE: Department of Health Services, Health Data and Statistics Branch.

TABLE 8-10 Live Birth Percentages by Race/Ethnicity and Mother's Age, California, 1985

	Age of Mother			
	10–14	15–19	10–19 Total	20 and Over
Hispanic	0.3%	14.8%	15.1%	84.9%
White	0.1	7.9	8.0	92.0
Black	0.6	18.2	18.8	81.2
Asian	0.1	4.1	4.2	95.8
All others	0.1	7.2	7.3	92.7
Total	0.2	10.7	10.9	89.1

SOURCE: Department of Health Services, Health Data and Statistics Branch.

care is available, many teenagers delay seeking it. Often they deny or do not know that they are pregnant, and often they do not know how to get care. This negligence greatly increases their medical risks.

Fathers of babies born to teenage mothers are typically several years older than the females. More than a fourth (28 percent) of these fathers are teenagers themselves. About half are between ages 20 and 24 and an additional 20 percent are over the age of 24 (Appendix Table 8-1).

Teenagers who marry to legitimize a pregnancy often do not fare much better than those who remain single. The marriage often disrupts the education of both parents. They earn lower wages, are more likely to divorce, and are morely likely to have additional children. Although data are not formally collected, approximately 25 percent of male high school dropouts in California are assumed to be the direct result of adolescent childbearing.[70] Since adolescent pregnancy is known to be one of the major causes of dropping out of school, school districts should institute dropout prevention programs that offer additional services for pregnant and parenting adolescents.

Impact of Adolescent Pregnancy on Infants

A strong pattern shows that more low birth weight babies are being born to teenagers under age 15 than to teenagers ages 18-19 and women between the ages of 20 and 34.[71] For example, in 1986 in California, the percentages of low birth weight babies was 9.9 for mothers under age 15, 8.2 percent for mothers aged 15-17, and 6.9 percent for mothers aged 18-19. These statistics contrast sharply to the 5.8 percent low birth weight rate experienced by women between the ages of 20 and 30. There are no differences in the mortality rates for infants born to teens compared to those born to older women, when other factors are controlled, but these babies face a multitude of risks because of low birth weights. Such risks include more frequent childhood illnesses, more hospitalization (especially during the first year), and poorer cognition, leading to poor performance in school. Another risk faced by babies of teenage parents is a significantly higher rate of accidental deaths during the first year of life.[72]

TABLE 8-11 Live Births by Parental Care Initiation and Mother's Age, California, 1985

Month care began	10	11	12	13	14	15	16	17	18	19	10–19, Total	Percentage	20+ Total	Percentage
First trimester	0	0	4	36	276	1,116	2,805	4,977	7,570	11,211	27,995	54.6%	348,589	74.0%
Second trimester	0	1	3	50	323	995	2,063	3,168	4,582	5,712	16,897	33.0	87,149	18.5
Third trimester	0	1	4	25	80	271	459	702	994	1,246	3,782	7.4	18,140	3.9
No care	0	0	5	15	34	104	162	245	370	446	1,301	2.7	6,771	1.4
Not stated	0	0	0	5	28	68	141	231	308	419	1,200	2.3	10,167	2.2
Total	0	2	16	131	741	2,554	5,630	9,323	13,824	19,034	51,255	100.0%	470,816	100.0%

SOURCE: Department of Health Services, Health Data and Statistics Branch.

Not unrelated to poorer health status and neglect of offspring are poorer outcomes for mental development.[73] Overall, there were only small and generally not statistically significant differences in first-year cognitive development. Differences emerge more clearly when the children begin school. Thus, the poor school performance, sometimes also coupled with behavior problems, of teenage parents may be repeated by their offspring.

Social Service Issues

Women who bear their first child as teenagers have lower-status occupations, accumulate less work experience, and receive lower hourly and annual wages than do women who delay child bearing until adulthood. Nearly 53 percent of the total welfare budget goes to women who first gave birth as teenagers, and teen mothers without a high school diploma are twice as likely as graduates to receive AFDC services.[74] Two thirds of teenage mothers with children under age 5 are poor.[75] Thus, not only is giving birth as a teenager costly to the mother, it is costly to the nation.

In 1985, the nation spent approximately $16.5 billion to support families headed by mothers who first gave birth as teenagers. The 385,000 children who were born to adolescents in 1985 will receive $6 billion dollars in welfare benefits during the next twenty years.[76] In 1985 California itself spent a total of $3.61 billion on families begun by a teenage mother. Conservative estimates of the anticipated costs of California's 51,255 adolescent births in 1985 run as high as $779 million over the next twenty years, calculated in 1985 dollars.[77] These estimates include only the cost of public assistance (AFDC), food stamps, and health services. They do not consider the cost of any special services such as special education, nor the cost of special intervention programs such as the school-based Pregnant Minor Program or the School Age Parents and Infant Development Programs conducted under the auspices of the California State Department of Education.

Educational Impact of Adolescent Pregnancy

Among the most important aspects of adolescent pregnancy are the short- and long-term effects of an unintended pregnancy and birth on a young woman's or man's education. Recent national surveys provide substantial new evidence that limited schooling and limited economic opportunities are related to adolescent childbearing, with teenage parenthood appearing both as an antecedent and a consequence. Approximately 25 percent of the dropout-childbearing syndrome occurs prior to conception.[78] National studies show that youth with poor basic skills on standardized tests, regardless of race, are more than three times as likely to become parents as those with average or better basic skills. Almost all racial differences in the incidence of teen parenthood disappear when income and skill deficits are taken into account.[79] As in other health outcomes, the effects of poverty are clearly an important factor.

Early parenthood often limits opportunities for further education and the development of job skills. Specific barriers that teenage parents face include lack of accessible and affordable child care; lack of transportation among home, school, and day care; and ineffective or nonexistent policies to ensure that parenting teens can remain in their home schools. Many schools fail to accommodate adequately the dual role of parent and student so that these teens can complete their high school education.

An estimated 51,700 teenage mothers and 20,000 pregnant teens aged 18 and under resided in California in 1985. It is projected that a total of 74,400 pregnant and parenting teens will live in California in 1992. Yet, in 1985–86 only 18,500 students, or 25.8 percent of eligible pregnant and parenting teens, were served by California's special programs for this population.[80] Thus, conservatively, an additional 53,200 young women a [illegible] need of comprehensive educational services to enable them [illegible] tinue their schooling through graduation. Simply to maintain the current level of limited coverage, additional services for 800 teens will be needed by 1992.

Special Interventions for Pregnant and Parenting Adolescents

Three California programs that address the special needs of pregnant and parenting teens are available in some school districts. The Pregnant Minor Program (PM) and the School Age Parenting and Infant Development Program (SAPID) operate within the State Department of Education. The Adolescent Family Life Program (AFLP) is administered by the Department of Health Services. However, of the 1,025 school districts, only 16 percent have any of the following: Pregnant Minor Program (119 programs operating), School Age Parenting and Infant Development (SAPID) Programs (49 programs operating), or Adolescent Family Life Programs (AFLP) (29 programs operating in twenty-six counties).

The pregnant minor programs provide academic instruction, prenatal and postnatal education, family planning information, nutritional education, and frequently counseling for pregnant adolescents through the semester following childbirth. The programs may be located at or near a comprehensive or continuation high school, or they may be a self-contained elsewhere. The pregnant minor program currently faces obstacles because it is not possible to determine whether districts receiving funds to serve pregnant minors are actually spending them to serve this population. State dollars are not "trackable," and funds are unavailable to expand existing programs or to start new ones. Also, no compliance regulations exist to ensure that programs are of high quality.[81] For example, data on program completion and performance outcomes are lacking, particularly in regard to dropout status and high school completion. This lack of data precludes an accurate assessment of the program's impact.

The SAPID program was established to encourage parenting students to remain in school by providing child care on or near the school site, transportation, and a parenting education course. Guidelines encourage the integration of SAPID into the regular school curriculum, either at a comprehensive or a continuation high school. The program has grown from thirteen school districts on a state budget of $595,750 to an allocation of $6,668,000 in the 1986–87 budget year to support sixty-one programs. Coordination of the PM and SAPID programs on the local level remains fragmented. Many districts and county offices of education have only one of the two programs. Even in districts where both programs exist, it is difficult to integrate them. In addition, state laws, regulations or administrative procedures do not require the coordination of these services.[82]

The AFLP program provides continuous case management services to pregnant and parenting adolescents, their infants, and grandparents within a comprehensive local network of services and resources. Each pregnant or parenting adolescent has a case manager who monitors her or his access to educational, medical, and social services based on the initial intake assessment. Grants are provided to counties and other public and private agencies to establish regional projects to provide comprehensive, coordinated care systems.

Although the program has been in operation for only two years, local agencies in twenty-six counties have long waiting lists for the 4,000 slots targeted for this project. Thus many parts of the state are underserved or not served by this program. The community network concept that is part of this program is essential to providing effective services because it allows service providers to share information, reduces gaps and overlaps in services, and maximizes continuous care for the target population and their children.[83] Linkage agreements (formal and informal) help agencies clarify their roles with respect to each other, thus avoiding duplication of services and enhancing service delivery.

Prevention of Adolescent Pregnancy

There is a complex relationship between vulnerable young people—those who are poor, members of ethnic minorities, experiencing difficulties in school, engaging in risky behavior— and unintended pregnancy. Facing what seems to be an unending cycle of poverty, powerlessness, and alienation, teenagers may see becoming a parent as an attractive option. Strategies to prevent adolescent births and pregnancy must demonstrate to youths that more attractive options do exist. Traditional pregnancy prevention and substance abuse education programs emphasized factual information about the adverse health, social, and legal consequences of using drugs, or focused on the anatomical and physiological aspects of methods of contraception. These approaches have been limited in success, for they fail to help youth translate knowledge into behavior. New approaches teach junior and senior high school students a range of life skills designed to enhance self-esteem and social competence, thereby reducing the motivations to engage in risk-taking behavior. They also teach specific techniques for effectively resisting social influences to participate in activities such as unprotected intercourse.

Adolescents must have both the desire and the capacity to delay pregnancy. In order to achieve this goal, they need information and resources and must perceive that to delay pregnancy is worthwhile. Teens who see a future for themselves are less likely to become sexually involved at an early age and are more likely to use contraception effectively.[84] One of the primary strategies for pregnancy prevention begins in the classroom. This is where academic skills and family life education are acquired, and there are many opportunities for building self-esteem and self-sufficiency.

Although a variety of efforts, programs, and funding mechanisms are currently in place to cope with teen pregnancy, many of them are limited in scope, undersized, and fragmented in their approach. Achieving the goals of preventing adolescent pregnancy, improving the health of those babies that are born, supporting teenage families, and expanding educational and employment options, requires extensive policy changes. These include (1) a state-coordinated initiative aimed at both the development of interagency planning and the coordination of service delivery systems; (2) economic incentives to stimulate local communities to develop educational, health, and social service programs that keep students— particularly pregnant and parenting teenagers— in school (such programs should also be seeking to prevent additional births during the teenage years); (3) greater resources devoted to ensuring that pregnant teenagers receive adequate prenatal health care; (4) programs that encourage teenage fathers, as well as the parents of teenage parents, to support the young mother and her child; and (5) prevention strategies of demonstrated effectiveness.

Dental Health and Dental Health Services

Ten years ago, dental health program planners had an easy time describing children's dental health needs: dental disease was ubiquitous, dental caries was said to be "more common than the common cold," and it was safe to assume that almost all children would benefit from routine periodic dental examinations, prophylaxis, and treatment.

There has been a marked decline in the prevalence of dental caries during the past decade. It has also been recognized that gingival (gum) disease, while still not completely understood, does not lead inevitably to more advanced periodontal disease. Yet some groups of children, particularly poor and minority children, remain at high risk of developing dental problems, and their numbers are increasing in California. Statistics collected in Monterey and San Bernardino counties for an evaluation of the state's Dental Disease Prevention Program, showed that the incidence of caries is highly concentrated – 25 percent of the children suffered 80 percent of the tooth decay (Table 8-12). These children are most often from poor or minority-group families.

Mexican-American children between ages 6 and 17, for example, have more than twice the mean number of untreated decayed teeth than the average for all children in the same regions. Immigrant children surveyed in San Francisco, in particular

Filipino children, have considerably more caries than even the recent Hispanic immigrants to that city. The survey found that 75 percent of Filipino children had dental conditions that were considered "serious" by the examiners.[85]

Water fluoridation is the single most important explanation of differences in the prevalence of dental caries. An evaluation of the state Health Department's Prevention Dental Program found that children living in communities with fluoridated water experience

TABLE 8-12 Caries Prevalence in California Children

	Average DMFS[a]	Average DMFS DDPP[c] 1981–82	
Age	NIDR Region VII[b] 1979–80	San Bernardino County (naturally fluoridated)	Monterey County (nonfluoridated)
5	0.15	0.08	0.20
6	0.12	0.54	0.61
7	0.71	0.84	1.29
8	1.30	1.43	2.47
9	1.92	2.01	3.66
10	2.91	2.92	3.84
11	3.19	3.13	6.56
12	4.50	n.a.	n.a.
13	5.38	n.a.	n.a.
14	6.74	n.a.	n.a.
15	8.07	n.a.	n.a.
16	10.80	n.a.	n.a.
17	12.33	n.a.	n.a.

[a] Decayed, missing, and filled tooth surfaces.

[b] Region VII included 5,473 children in California, Oregon, and Washington. NIDR stands for National Institute of Dental Research.

[c] Dental Disease Prevention Program included examinations of 2,939 children.

SOURCE: U.S. Department of Health and Human Services, *The Prevalence of Dental Caries in United States Children, 1979–1980: The National Dental Caries Prevalence Survey*, National Caries Program, National Institute of Dental Research (NIDR), 1981. S.J. Silverstein, H.F. Pollick, and J.I. Fine, *Evaluation of the State of California Children's Dental Disease Prevention Program*, University of California, Center for Dental Services Research, 1985.

25 to 47 percent less tooth decay than those who drink nonfluoridated water.

Another likely cause for the different rates of decay is that poor children are more often unable to secure preventive or curative treatment for their dental problems. In many counties, the number of dentists accepting new MediCal patients is rapidly declining and in several counties no dentists will accept new MediCal patients. In 1986, none of the dentists in the Redwood Empire Dental Society, which represents Sonoma, Lake, and Mendocino counties, would accept new MediCal patients. By far the most frequent reason cited by these dentists for their refusal to see these patients is the low rate of reimbursement for treatment. For many dentists, the reimbursement rates provided by the cost-conscious state health insurance bureaucracy do not even cover their overhead costs.

TABLE 8-13 Untreated Dental Caries of Permanent Teeth in Hispanic Children, Mean Number of Decayed Teeth

Age	NIDR[a]	HHANES[b]	S.F.[c]
6	0.06	0.10	0.13
7	0.15	0.25	0.64
8	0.20	0.33	0.80
9	0.19	0.30	0.90
10	0.28	0.55	0.63
11	0.32	0.69	1.84
12	0.46	0.91	n.a.
13	0.42	0.94	n.a.
14	0.47	0.85	n.a.
15	0.51	1.37	n.a.
16	0.51	1.42	n.a.
17	0.48	1.32	n.a.

[a] NIDR (National Institute of Dental Research) data from the 1979–80 National Dental Caries Prevalence Survey.

[b] HHanes data from the 1982–84 Hispanic Health and Nutrition Examination Survey (sample from Arizona, Colorado, California, New Mexico, Texas, New York City, and Miami).

[c] Data from H.F.Pollick, A.J. Rice, and D. Echenberg, "Dental Health of Recent Immigrant Children in San Francisco Elementary Newcomer Schools," *American Journal of Public Health*, 1987.

SOURCE: H.F. Pollick, "Hispanic Health and Nutrition Examination Survey (HHANES): Preliminary Dental Examination Findings," paper presented at annual meeting of the American Association of Public Health Dentistry, Los Vegas, Nevada, October 8, 1987.

Children covered by MediCal are less likely to use preventive dental services than other children. In addition, the system is actually structured to discourage the use of these services. The Child Health and Disability Prevention (CHDP) program regulations, for example, require that all eligible children be referred annually to a dentist for an examination and necessary treatment. But MediCal, which is supposed to pay for this service, allows for only a single dental examination per dentist in the child's lifetime. MediCal children also do not benefit from the most effective decay-preventive procedure since the advent of fluorides: dental sealants. For three successive legislative sessions, Governor George Deukmejian has vetoed legislation that would have added sealants—a benefit available to other children in California and to Medicaid children in twenty-two other states—as a covered benefit under MediCal.

Strategies for Prevention of Dental Caries and Peridontal Disease

Actually, individual office-based dental treatments promise only a fraction of the solution for preventing dental caries and periodontal disease, compared to other methods. These diseases are for the most part easily and inexpensively preventable. Fluorides in various forms—water fluoridation, dietary fluoride supplements, fluoride dentifrices, fluoride mouth rinses, and topical fluoride applications— have long been recognized for their role in caries prevention. Many studies have documented caries reductions of between 50 percent and 65 percent from fluoridation. Research has found fluoridation to have a benefit-cost ratio of as high as 50:1. But, only 17 percent of California's population has access to fluoridated water, even though it is considered by far the most effective anticaries method. Nationally, about 60 percent of community water supplies are fluoridated, including almost all major cities. But in California several of the largest cities— Los Angeles, San Diego, San Jose, and Sacramento— remain unfluoridated.

In the absence of water fluoridation, fluoride mouth rinsing is considered the next most effective community-based method of administering fluoride. In California, more than 373,000 children in preschool through sixth grade participate in the school-based Children's Dental Disease Prevention Program (DDPP). The program, sponsored by the State Department of Health Services, includes either weekly fluoride mouth rinsing or daily fluoride supplements. Fluoride mouth rinsing is believed to reduce caries by approximately 35 percent in nonfluoridated communities. The state's Dental Health Section has estimated that if all children in grades K–12 participated in this program, taxpayers would save $22.5 million spent on dental care each year. Despite this potential, less than 16 percent of the K–6 population participates in the program, and children in junior and senior high school— who are at highest risk for caries— have no access to preventive programs. The evaluation of the DDPP demonstrated that half of the children's tooth decay had already occurred by the time they reached kindergarten. Although preschool children were recently made eligible for the DDPP program, only ten thousand preschool children are currently enrolled.

For the prevention of periodontal disease, there is no "magic bullet" equivalent of fluoride. The regular removal of dental plaque by daily toothbrushing and the use of dental floss remains the only way currently known to prevent this disease. Thus, prevention depends on the regular practice of skills that most children have not been trained to use. Although most school-based dental health education programs have not been shown to be effective in improving children's oral health, California's DDPP has shown promise. This program has demonstrated statistically significant reductions in gingival inflammation of 20 percent or more for children in grades K–6.

The most prevalent children's dental diseases— caries and periodontal disease— can be prevented with currently available technology. What is needed is a way to promote and expand the use of these proven preventive measures in community-based settings. Community water fluoridation still represents the most cost-effective method available for caries prevention. But because fluoridation often becomes a political rather than a public health issue, the community organization needed to implement such a program is beyond the ability of many communities to undertake. State leadership could provide the needed impetus, but no funding or organized effort on behalf of fluoridation has come from the state government in recent years.

School-based preventive dental programs have demonstrated their effectiveness in reducing dental disease, but they are available to only a small portion of the population. There is a need to expand such programs to children from preschool through high school. Junior and senior high school students are currently served by no programs, although they are at highest risk of developing dental problems. The scope of services provided by school-based programs also needs to be expanded to include the most effective preventive agents available, including dental sealants. Finally, the fact that most dental disease is concentrated in relatively few children suggests the need to effectively target children's dental health programs to those at highest risk, especially poor and minority-group children. The worsening problem of access to dental care must be addressed to bring poor and minority-group children's use of dental services at least to the level afforded other children. To do so, MediCal needs to be restructed to increase dentist participation and provide more preventive services.

Special Problems

Children with Developmental Problems

Peculiar to the health of children is the category of developmental disabilities. The human organism develops physically, mentally, and emotionally. The processes of development are complex and depend for their successful unfolding on a set of relationships between the developing human and the environment. A small, but significant and growing, number of children suffer from some disturbance in this delicate development process. The number of children who receive services from the state for the disability that results– whether it results from genetic factors, various forms of deprivation, prenatal and postnatal insults, environmental and psychosocial stresses, or some combination of these adverse conditions– is on the rise. And mounting evidence suggests that only a small portion of the children who would benefit from these services is being served.

The two main systems for serving these children are the special education programs in the public schools and the State Department of Developmental Services (DDS). The special education system, required under the federal Education for All Handicapped Children Act of 1975, provides services to children who are mentally retarded, blind, deaf, or struggling with any of a range of learning disabilities. Of the 412,579 students in the special education system, more than 80 percent receive help for speech impairments or learning disabilities.

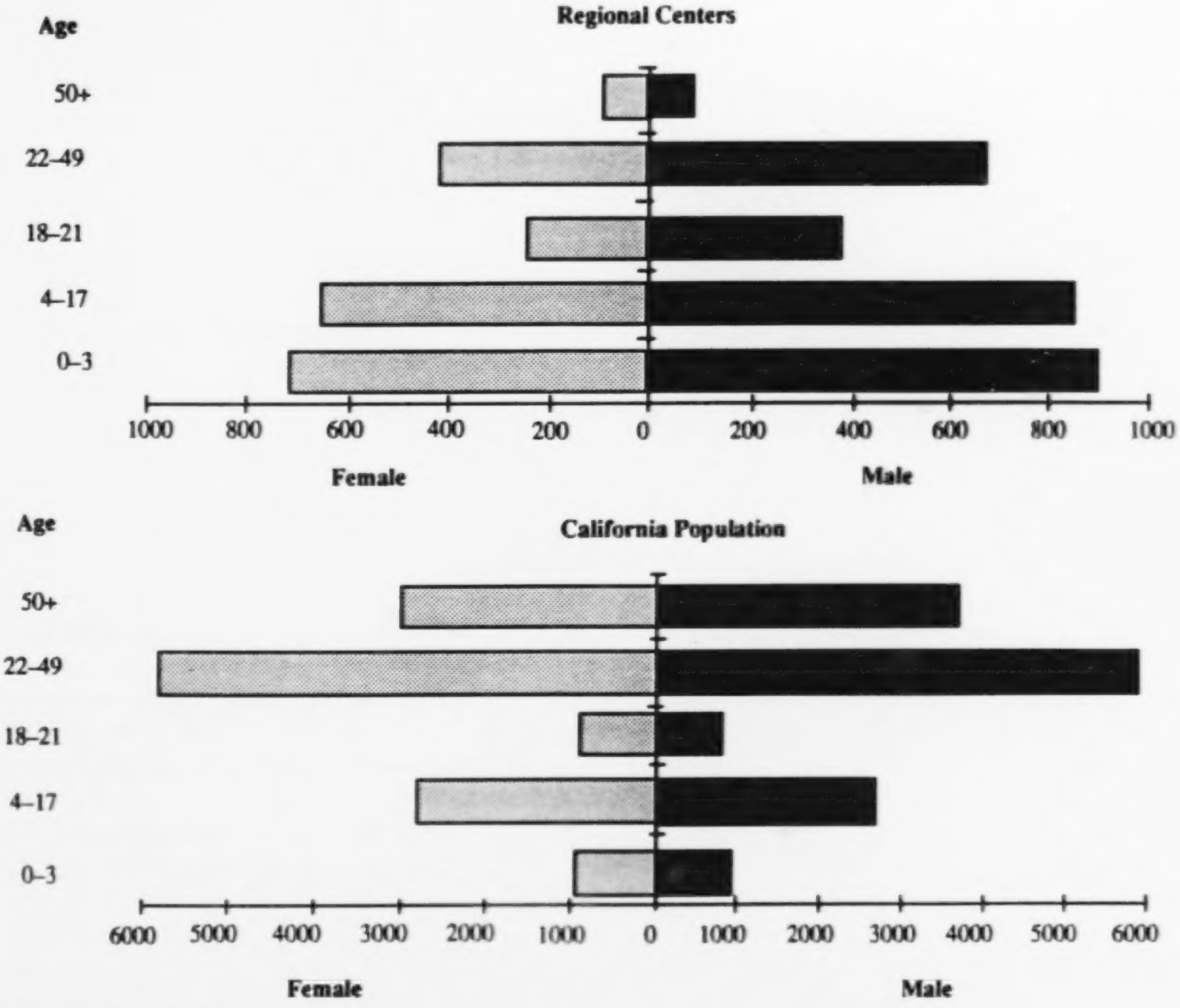
California's Lanterman Developmental Disabilities Services Act of 1978 defined a developmental disability as "a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial handicap for such individual."[86] These conditions include mental retardation, cerebral palsy, epilepsy, and autism. Children with severe physical disabilities are generally served by California Children's Services, a separate division within the California Department of Health Services. At present the DDS program serves 28,850 children.

The proportion of new DDS clients who are children is increasing rapidly. In 1981–82, 18.4 percent of the new clients were children. By 1986–87, that percentage had risen to 36 percent. This trend reflects the global phenomenon of a rise in the number of premature and low birth weight infants surviving the perinatal period. Babies born in the 1960s weighing three to four and a half pounds had only a 38 percent chance of survival. In the 1980s, however, 90 to 94 percent of those infants survive. Unfortunately, these survivors remain at high risk for developmental problems because the possibility of central nervous system damage increases at lower birth weights.[87]

In fact, among new clients entering the DDS system in 1986–87, low birth weight was the most common risk factor reported. Twenty percent of new clients up through age 3, and 10 percent of the clients aged 4 to 17 were reported to have had low birth weights. Clients entering the DDS system after infancy were more likely to have been the victims of vehicular or other accidents, child abuse, or neglect. In addition, 10 percent of the new clients up through age 3 were born to women older than 34 and 4.7 percent to women who abused alcohol. Other risks include birth trauma, congenital anomalies, neonatal illness, and neglect causing failure to thrive (Table 8-14). New clients tend to be younger, more predominantly male, nonwhite, and less likely to be placed out of the home (Figure 8-14).

The majority (56 percent) of children entering the DDS system do so because of mental retardation. Most of these exhibit mild retardation; only 17 percent of the mentally retarded are

FIGURE 8-14 New Regional Center Clients and California Population, by Age and Sex



SOURCE: California Department of Developmental Services.

TABLE 8-14 Risk Factors Associated with Developmental Disabilities Within Age Groups (New Regional Center Clients, October 1, 1986, to July 31, 1987)

Risk Factor	Ages 0–3		Ages 4–17	
	Number	Percent	Number	Percent
Low birth weight	323	20.4%	144	9.9%
Maternal age 35 or older	144	9.1	62	4.1
Family history of mental retardation	126	7.9	122	8.3
Psychosocial (environmental) deprivation	102	6.4	97	6.6
Child abuse and/or neglect	85	5.4	96	6.6
Drug or alchohol abuse	75	4.7	57	3.9
Teen pregnancy	58	3.7	57	3.9
Accidents	46	3.0	78	5.3
Environmental toxins	10	0.6	4	0.3
Other	124	7.8	99	6.8

SOURCE: California State Department of Developmental Services.

diagnosed as severely or profoundly retarded. With regard to other disabilities, younger clients are more likely to display multiple problems than are those who enter the system later in life. This is because multiple congenital anomalies and other serious birth defects are more likely to be apparent earlier than are milder disabilities.

Services for Developmentally Disabled Children

California's system of assisting developmentally disabled people has been operated by the Department of Developmental Services (DDS) since 1978. Before then, services to the disabled were dispersed among various state and local health and mental health departments. The DDS was created to specialize in delivering services to this population.

The goals of the DDS are to provide developmentally disabled people with safe places to live, job possibilities, and the opportunity to lead happy and productive lives. In carrying out its objectives, DDS emphasizes provision of services in the least restrictive setting and integration of disabled people into the larger community, as near as possible to their family and friends.

The Lanterman Act, the legislation that created the DDS, stimulated the development of twenty-one regional centers and seven developmental centers. Regional centers serve as fixed points of contact in the community. They provide a continuum of services: identification of developmentally disabled children in need of services, outreach, intake, diagnosis and assessment, prevention, advocacy, monitoring and evaluation, and individual case management. Some services are provided at the centers, while others, such as special education or medical and dental care, are purchased from approved vendors or generic agencies. Regional centers also purchase residential and in-home support, transportation, and respite care for clients. Support services for families are included in those provided for children.

The DDS also collects extensive information on each of its clients through an annual Client Development Evaluation Report (CDER). Demographic, diagnostic, and client assessment data in six areas of development are collected. This system, unique among programs serving children in California, presents a wealth of information on the children receiving developmental services. It provides the basis for most of the client statistics presented in this report.

All DDS clients enter the system through the regional centers. If a child needs out-of-home placement, the regional center secures that placement. Seven state developmental centers, previously called *state hospitals*, care for about 2 percent of DDS children. These clients tend to be older and to have severe, often multiple, disabilities; one-quarter of developmental center residents bear the combined burdens of mental retardation, epilepsy, and cerebral palsy. Often, developmental center children also exhibit maladaptive behavior or have medical problems in addition to their primary disability. It appears that most regional centers have been encouraging parents to keep their children at home; in the past ten years, the number of school-age residents living in developmental centers has dropped by 74.5 percent.

Two other general modes of residential care exist for more severely disabled clients. Three percent of all children served live in long-term health facilities, and 11 percent live in community care facilities. Health facilities, such as skilled nursing and intermediate care facilities, have seen a recent 2.4 percent increase in their younger patient caseload. With the increase in the number of severely disabled children, partly as a result of the efforts of neonatal intensive care nurseries, and the greater number of children entering the system, there is a higher demand for health facilities providing out-of-home care. At the same time, there is a trend toward parents keeping disabled children at home, except when medical needs or severe emotional disturbances render that impossible.

Of children under 18 years of age in the DDS population, 58 percent are male. Males are more likely than females (59 percent of males compared to 41 percent of females) to be treated in a residential facility. Especially as they enter adolescence, misbehavior of boys is often more troublesome for families.

Various advocacy groups, professional associations, and parent groups have been successful in defending the interests of the disabled in the face of government belt tightening. The DDS has survived federal budget cuts better than many other programs for children. The amount of money spent per child has actually increased in the past decade. This has occurred because the department's spending on community services has increased faster than its regional center client caseload. From fiscal year 1978–79 through fiscal year 1986–87, expenditures for regional center services tripled, increasing from $124 million to $390 million. During the same period, the regional center caseload expanded by 67 percent.

This level of spending has meant that most parents are generally satisfied with the services their children receive. The regional center assembles a comprehensive package of services to help a child in all areas of need. Professionals then provide the needed services. The system is designed to address the entire array of problems associated with a developmental disability.

Some DDS clients, however, do not receive the services they need. Regional center surveys of clients, families, and providers, in addition to DDS's Long Range Plan (1986 to 1991), point to needs and populations that are not fully addressed. The special requirements of rural populations deserve greater attention, as do increasing demands for preschool, day care, small residential facilities, and respite services. In addition, teenagers need more assistance in learning to live independently.[88]

Of even greater concern, however, are the number of disabled and needy children not served within the system. The San Diego Regional Center recently tried to calculate the number of unserved children. Researchers first assumed a 4.6 percent developmental disability rate nationwide, and then assumed that approximately half of those children were not disabled enough to require DDS services; they then were able to estimate that they were reaching only a small portion, fewer than 10 percent, of those who would benefit from their services.[89]

Additional research is necessary to ascertain whether the system is really missing significant numbers of developmentally needy children who could be helped by DDS and if so, why? A study conducted by Berkeley Planning Associates found that only 1.17 percent of California's population fit the federal definition of developmentally disabled. The authors contend that the actual demand for services at any given time falls far short of the total number of functionally limited individuals in California. They suggest that this shortfall exists because individuals are being served by family, church, and other nonpublic providers, and that demand for services fluctuates for any given person over time.[90]

Specific areas for improving California's DDS can be identified. Programs are needed that target the growing numbers of infants and young children with severe developmental disabilities, a result of the growing success of high-technology neonatal intensive care and increases in the prevalence of drug-exposed infants. Unmet needs for services such as preschool and day care, small residential facilities and respite care, as well as services for particular groups including rural populations and adolescents, are demonstrable and should be effectively addressed.

More accurate and specific data on the effectiveness of outreach and identification should be gathered, along with data on whether the population needing developmental services is actually being served. This type of analysis would include accurate data on the incidence of neurologically damaged premature infants and drug-exposed infant births and on the number of abused and neglected children entering the child welfare system with serious developmental delays.

Developmental services could be more effectively delivered through the coordination of DDS clients with California Children's Services (CCS), the California Health and Disability Prevention Program (CHDP), and special education programs in the schools. For infants and children up through age 3, coordination among CCS, special education, CHDP, and maternal and child health programs is needed.

These children may suffer from either multiple medical problems and physical disabilities or only mental (cognitive and emotional) delays. Currently these infants can be eligible for services provided by CCS or Maternal and Child Health High Risk Infant Follow-up Projects. Recent analysis of efforts to coordinate services to these infants have demonstrated the beneficial effects of interagency coordination through local interagency councils.[91]

TABLE 8-15 Distribution of California's Children with Developmental Problems in Various Educational Environments, 1987

	Regular Class*		Separate Class		Separate School		Total
	Number	Percentage	Number	Percentage	Number	Percentage	
Mentally retarded or emotionally disturbed	2,666	7%	33,207	85%	3,299	8%	39,172
Sensory or speech impaired	99,306	88	12,824	11	195	1	112,325
Physically impaired	13,503	61	8,353	38	169	1	22,025
Learning disabled	163,425	70	67,777	29	796	1	231,998
Multihandicapped	566	8	6094	86	399	6	7,059
Total	279,466	68	128,255	31	4,856	1	412,579

* These children spend between one hour and half of the day in a special education setting.

Note: This chart does not include institutionalized children.

SOURCE: California State Department of Education, Division of Special Education.

Physically Handicapped Children

All Californians under the age of 21 who suffer from a wide range of physical handicaps are provided with medical care through California Children's Services (CCS). The services of the program include a diagnostic evaluation, a treatment plan and continuous medical services, monitoring and medical case management, and physical and occupational therapy in conjunction with the state Department of Education.

The program's financial eligibility requirements are more liberal in California than in many states. Currently, children are eligible for CCS services if the family's adjusted gross income is below $40,000 a year or if the child's annual medical care expenses are expected to exceed 20 percent of the family's adjusted gross income.

The budget for this program now exceeds $70 million, and contributions from the state and counties are growing more rapidly than the federal government's share. Counties now contribute about 24 percent of the program's costs. The demand for these services is increasing, however, and resources will likely continue to be scarce.

Chronically Ill Children

Data on the prevalence of chronic illness are not available specifically for California's children. But national data collected by the National Center for Health Statistics through the National Health Interview Survey indicate that the percentage of children limited in their school or play activities due to chronic illness has more than doubled since 1960.[92] The cause of the rapid rate of increase is unclear, but several explanations have been offered. Almost half of the overall increase may be attributable to changes in data collection methods. Other explanations include better detection of chronic illness in the community and increasing survival of disabled and low birth weight babies.

The increase in the caseload of California Children's Services, the program that treats chronic illnesses and disabilities in California, has not kept pace with the national figures. In the past two years, however, CCS caseloads have increased from 74,000 cases annually in early 1984 to 87,000 cases annually in early 1986. Population growth in California during the next decade will contribute to further increases of the CCS caseload. Conditions eligible for treatment through the CCS are detailed in Table 8-16.

Projections of continued increases in childhood chronic illnesses force one to ask whether sufficient funds will be available in the future. The federal government has carried out substantial cutbacks in most children's programs, including maternal and child health services.

Federal CCS and maternal and child health funds were reduced 25 percent and combined into a single block grant in 1981. The federal contribution to CCS in California through the new block grant program has increased 16 percent since then, measured in current dollars. However, when the federal funding levels are adjusted by the medical care component of the Consumer Price Index, a different trend emerges. Federal payments for CCS have declined by 21 percent in inflation-adjusted dollars. State spending, which has increased by 34 percent, has filled in part of the gap in federal funds. Still, when medical care inflation is considered, state spending is down 8 percent since 1981.

Counties are required to provide a $1 match for every $3 received from the state and federal government. But various spending limitation measures approved by voters have limited the ability of counties to raise funds. Consequently, some counties are unable to provide even this one-third match.

In the past, financial constraints have led to tighter eligibility restrictions for CCS services. In 1978, eligibility for CCS reimbursement was restricted to families with incomes less than $100,000. In 1982, the maximum allowable family income was reduced to $40,000. Families with incomes above $40,000 may be eligible if the family's yearly cost of care for the child is expected to exceed 20 percent of gross income (Table 8-17).

TABLE 8-16 California Children's Services: Eligible Medical Conditions

1. Orthopedic conditions due to infection, injury, or congenital malformation (flat feet, tibial torsion, and pigeon toe are excluded)
2. Conditions requiring plastic reconstruction, such as cleft lip, oro-facial anomalies, and burns
3. Conditions requiring orthodontic reconstrucion, such as cleft palate, severe malocclusion, and oro-facial anomalies
4. Eye conditions leading to a loss of vision (ordinary refractive errors, inflammatory conditions, chronic chalazion, and strabismus cases where refraction and glasses are the only services required, are excluded)
5. Ear conditions, for example, mastoiditis, chronic otitis media, and significant hearing loss (serous otitis media and hearing loss resulting therefrom are excluded)
6. Rheumatic fever
7. Nephritis, nephrosis, or the nephrotic syndrome
8. Phenylketonuria
9. Hemophilia
10. Hyaline membrane disease (also known as *respiratory distress syndrome*)
11. Endocrine and/or metabolic disorders posing medical management problems or problems of diagnosis
12. Convulsive disorders posing medical management problems or problems of diagnosis
13. Blood dyscrasias
14. All neoplasms
15. Severe skin disorders such as epidermolysis bullosa
16. Chronic pulmonary conditions such as cystic fibrosis, bronchiectasis, and lung abscess
17. Congenital anomalies causing disabling or disfiguring handicaps
18. Conditions of the nervous system such as inflammatory disease of the central nervous system that produces motor disabilities such as paralysis, and ataxia, and neuromuscular conditions such as cerebral palsy, and muscular dystrophy
19. Conditions resulting from accidents or poisoning that may be potentially handicapping, such as complicated fractures, brain and spinal cord injuries, and stricture of the esophagus
20. Severe adverse reaction to an immunization requiring extensive medical and related care
21. Other disabling or disfiguring conditions that are handicapping

TABLE 8-17 Expenditures for Direct Services and Funding Sources, California Children's Services, Fiscal Years, 1984–85 Through 1986–87 (estimated amounts, in thousands)

Funding Source	1984–85	1985–86	1986–87
State General Fund	$41,342	$39,448	$48,259
Federal funds	4,704	4,704	4,704
County funds	15,598	14,626	17,929
Family repayments	750	720	825
Total	$62,394	$58,778	$71,717

SOURCE: California Department of Health Services, California Children's Services, Program Data.

Prevention

Prevention is, of course, the preferred "treatment" for any disorder in children of any age. The enormous gains made in the area of child health over the past century have been made mostly through advances in preventive medicine. As a result of changing social conditions and advances in medical and public health knowledge, most children enter the world safe and sound, and experience a healthy childhood, free of serious illness or disability. But some children will suffer from serious health conditions, stemming from such complex causes as genetic abnormalities, developmental retardation, serious injuries, and emotional troubles engendered by family problems. Although the causes of childhood illness today are not nearly as amenable to "single-cause" cures as were simple infectious diseases, it is possible to identify "risk factors" and to understand how to make most effective use of direct preventive services.

Identification of risk factors (genetic, perinatal, familial, or environmental) and timely identification of an emerging condition increase the effectiveness of interventions. A problem can often be prevented if it is anticipated. Primary prevention—action taken to prevent a disease or disability or to promote health—is exemplified by parent education, immunizations, and the use of safety belts and car seats. Secondary prevention can minimize the impact of some conditions, if not prevent them from occurring altogether. One example of this is screening to detect anemia. Identification and prompt treatment of anemia can reduce or eliminate the lethargy, general dysfunction, and possible cognitive disability associated with the disorder. Lastly, once an illness or disorder occurs, prompt diagnosis and treatment can reverse, halt, or delay its progression.

Preventive health services can take various forms and occur in different settings. Recently, some of the most effective preventive programs, including programs to stop smoking, use safety belts, and adopt habits that decrease the likelihood of heart disease, have been mounted successfully with multimedia marketing and information campaigns. Other preventive services have been offered in schools. These include routine vision and hearing screening instruction promoting good health behaviors in children and child health information for parents. Other types of preventive services are most effectively delivered in a more traditional health care setting.

The low-income child eligible for MediCal is also eligible for preventive services through the federal Early Periodic Screening Diagnosis and Treatment Program (EPSDT), called the California Child Health Disabilities Prevention Program (CHDP). The EPSDT program was added to the Medicaid program in 1967 and was the most ambitious program of medical and psychosocial prevention ever launched in this country. Like many programs of the "War on Poverty," it attempted to break the cycle of poverty by improving the lot of individuals. The EPSDT program provided federal funds to states as part of the states' Medicaid allocations for screening, diagnosis, and treatment of health and developmental conditions.

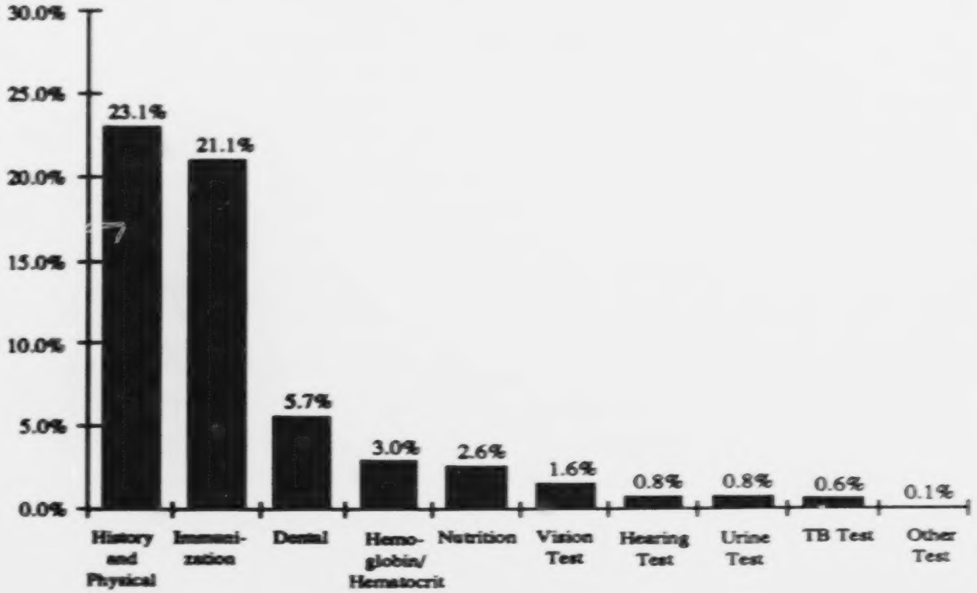
The goals of the CHDP program are to reduce the incidence of handicapping conditions and to stimulate the use of preventive health services. The program seeks to make maximum use of the child's usual source of health care and to ensure that high-quality services are available. The CHDP is supposed to provide for health assessments and referrals for diagnosis and treatment for all children from birth to 90 days after entry into the first grade, regardless of ability to pay.

During 1985 and 1986, this program paid for the assessment of the health of more than 600,000 children at a cost of about $40 million. MediCal paid for services to about 467,000 of those children and the state augmented that program by paying for health assessments of 173,000 children. The CHDP program grew at a rate of nearly 30 percent annually between 1973 and 1983 but it still serves only about 22 percent of eligible children. Of the 2.5 million children eligible for the CHDP screening and referral program in fiscal year 1983-84, only 555,000 were served.

Data for the 1981-82 fiscal year, drawn from a state evaluation of the program (Figure 8-15) show that nearly one in four of the children and adolescents who were given a physical examination and for whom a medical history was recorded was referred for diagnosis and treatment of an existing condition. More than one in five of those screened lacked immunizations. Smaller percentages of the 478,000 children assessed that year had dental, hematologic, vision, or hearing problems. Some also showed irregularities that were revealed in a test of urine or for tuberculosis. Although the vast majority of the children and youths who were assessed were demonstrated not to have a condition demanding referral for treatment, a significant portion needed follow-up services.

Surprisingly, these data do not indicate that the health assessors found a reportable level of developmental or psychosocial

FIGURE 8-15 Percent of Children Given CHDP Health Assessments Who Were Referred for Diagnosis and Treatment, by Problem Area, All Children Ages 0–20, Fiscal Year 1981–82



Note: Based on 477,811 children given health assessments. Percentages shown are based on the number of health problems referred for diagnosis and treatment compared to total number of children given health assessments.

SOURCE: California Department of Health Services, CHDP Program.

disorders. Other studies indicate that 5 to 15 percent of children are afflicted with developmental or other mental health problems. If the appropriate screenings were performed, such disorders should have been discovered. Although CHDP assessment standards cover some mental health and developmental issues, the application of these standards by practitioners seemingly falls far short of the ideal. Clearly, the growing recognition of the importance of mental health, developmental problems, and other problems as "new morbidities" indicates that the CHDP standards should be enforced. Enforcement should include training providers to appropriately identify and refer developmental and mental health problems.

In addition to screenings, county CHDP programs provide case management and follow-up services. When necessary, families are assisted in finding low-cost or free diagnosis and treatment. Through cooperative interagency agreements with the Department of Social Services, the CHDP provides information to eligible families through their local welfare department and offers assistance in arranging transportation and appropriate scheduling.

Currently, the CHDP program uses state general funds to provide health assistance to a variety of low-income children not in the MediCal program. Children between the ages of 4 and 6 are eligible for one free CHDP assessment to satisfy the school-entry health requirements, if the family income is less than 200 percent of the AFDC income standards. Children in Head Start and state-sponsored preschool programs are also eligible for free health assessments. In 1985 Governor Deukmejian approved augmenting

TABLE 8-18 California Child Health and Disability Prevention Program Costs and Number of Children Served, 1985–1986

	Assessment	Number of Children	Cost
Total Statewide	836,540	639,485	$40,359,560
MediCal	612,185	466,567	$30,268,667
State funded	224,355	172,918	$10,090,893

SOURCE: Department of Health Services, CHDP Program, The CHDP Screening Program.

the program's budget by $2.5 million to provide services for an additional 66,000 children younger than 13 months old. In 1987, that age limitation was raised to 29 months.

The CHDP offers the beginnings of the kind of program that is needed to address the whole range of California children's health needs. But it is as yet too small and too narrowly focused to be as much of a solution as it could be.

To reach its full capacity, the CHDP must be expanded to address the needs of far more children in the state. Secondly, the program must be broadened to better address behavioral and developmental problems, so that these problems can be identified and treated earlier and more effectively. In the interests of efficiency and economy, it would be appropriate to target the CHDP's limited services for known high-risk groups. These groups might include children in the foster care system, drug-exposed infants, the children of teenage mothers, teenagers themselves, and the growing number of homeless children in California.

In addition to increasing the number of children served, the program should increase the frequency and the types of services that are offered. In particular, a full complement of preventive services would help decrease the chances of serious morbidity, decreasing the great individual and societal costs of such illnesses. Finally, as a further tactic for targeting the CHDP services, the program could coordinate with the child welfare system and the public schools. The assessment and referral services could be profitably offered in school-based clinics and through coordinated case management to children in foster care.

Paying for Children's Health Services

Medical care has traditionally been a private transaction between the consumer and the provider. Health care for those unable to pay was for centuries a matter of "charity" provided by private philanthropy, churches, and, eventually, governments. The forms that medical charity took were varied: pro bono services by private physicians, special publicly or privately funded clinics, county hospitals, and hospitals funded by religious orders. Unlike almost all other developed countries, the United States has not developed a national health system that guarantees health care to all citizens. In some countries, most notably Great Britain, the national health system is publicly funded and administered, taking health care out of the private market system. In other countries, such as Canada, national publicly funded and administered health insurance is provided, but care is provided by private practitioners. However they are designed, these systems provide universal access to basic medical care for all citizens. The development of such national health systems or national health insurance was a response to the long-term rise in both medical effectiveness and medical costs. Their creation also resulted from a general belief that health care is a basic human need that society should support.

In the United States, the history of health care provision and financing can be divided into four periods:

1. Until the 1930s, health care was provided privately and paid for directly by consumers. Charity and local publicly funded

health care took care of those who could not afford to pay themselves.

2. Private health insurance plans grew rapidly from the 1930s to the 1960s as more workers began receiving health care benefits as part of their compensation.
3. From 1965 to 1980, a great expansion of public payment for health care took place, mainly through the Medicare and Medicaid programs for the elderly and the poor.
4. Since 1980, the health care system has been under pressure to contain costs as the cost to the public of meeting health care commitments has soared.

Two strategies for cost containment emerged in the late 1970s and early 1980s: regulation and competition. The Deukmejian administration in California, like the Reagan administration in Washington, asserted that regulation had failed to contain costs and supported competition as a cost-cutting method. Partly as a result of this policy, California now has a more extensive competitive health market than any other state. Also, medical costs in California are among the highest in the nation. The result of these policies is that the health care system has become a patchwork of public and private programs that mix both competitive and regulatory principles. This mixture often results in conflicting incentives for providers and patients, and raises doubts about whether it is possible to assure quality health care while restraining costs.

In 1986, approximately 63 percent of the nation's children under 13 years of age were covered by private health insurance.[93] Of this number, approximately 85 percent were covered through the parent's or guardian's employer-provided health insurance plan.

There is no standard "health insurance plan." The range and quality of private insurance plans varies widely. Many employer health insurance plans provide marginal or only partial coverage for dependents, and require substantial copayments and deductibles. This gap means considerable out-of-pocket payments are often necessary to cover children's health costs. In addition, and of crucial importance for children, many policies do not cover routine preventive care. This discourages families from making a potentially vital and cost-effective investment in the long-term health prospects of their children.

Coupling health insurance to employment means that local and national economic trends can have major effects on health insurance status. For example, high unemployment rates result in increased numbers of uninsured families. However, the issue of uninsured children has been a serious problem even in periods of low unemployment rates. In California, between 19 percent and 23 percent of children had no health insurance in 1985 despite a relatively prosperous state economy.[94]

What happens to those with no private health insurance? From the New Deal of the 1940s to the "Great Society" programs of the 1960s, the American approach has been to develop limited public insurance programs— Medicare for the elderly, Medicaid for the medically indigent. For poor children in need, the Medicaid program, financed by state and federal governments, has made important contributions toward ensuring that at least a minimal package of health services will be available.

MediCal, the state's version of Medicaid, has greatly improved access of the poor to health care. As a result, the program contributed to the decline of infant mortality between 1965 and 1984. MediCal currently serves nearly 1.5 million children and has standards of eligibility and benefits that are generous in comparison with most other states; of some thirty-three optional services that states can elect to provide under federal regulations, California now provides thirty-two.

In 1986, 17 percent of California children younger than age 18 were certified as eligible under the MediCal program. Additional children could gain eligibility should they apply or should their medical expenses exceed a set amount of their family income. All children on Aid to Families with Dependent Children (AFDC) are automatically eligible, making up 86 percent of MediCal clients. The remainder generally have incomes slightly above the AFDC eligibility threshhold, but gain eligibility through a special program known as the Medically Needy Program. This program was designed to ensure that children in families with incomes slightly above ADFC limits would not be denied MediCal coverage. California is one of approximately thirty-five states with a Medically Needy program.

But there are problems with this mixture of private and public health insurance. For example, there is a growing number of jobs in which the employer does not provide health insurance and the workers' earnings are not sufficient to pay for it themselves. As might be expected, those who have health insurance, either publicly or privately provided, make significantly greater use of health services than the so-called working poor who do not have it.[96]

Another policy problem is that of guaranteeing access for poor children to comprehensive health services even when they are eligible for MediCal services. Research nationally has shown that children relying on Medicaid are more likely to have physician contact in community clinics and in emergency rooms than in private doctors' offices. This episodic care in emergency rooms or community clinics is less desirable and often of lower quality than continuous care from one provider.

Although the state MediCal program could benefit from additional funding to improve access, state MediCal expenditures have continued to rise and now consume more than 20 percent of the state budget. During the past decade, the program has been a constant target for budget cuts. Yet MediCal expenses for children are relatively low. For example, although women and their children represent more than 70 percent of the Medicaid beneficiaries, they consume only about 25 percent of the program's expenditures. The largest share of Medicaid expenditures are for the elderly and the disabled, especially those in institutions. Currently the 5 percent of Medicaid beneficiaries in nursing homes consume 43 percent of Medicaid expenditures.

Furthermore, physician reimbursement rates under MediCal have not kept pace with inflation. The reimbursement rates today often do not cover a physician's basic overhead costs, forcing that physician to stop providing care to MediCal patients. Such circumstances are particularly difficult for women and children. As a result, the number of pediatricians limiting their treatment of MediCal patients increased between 1977 and 1983. Obstetricians were already fleeing the medical marketplace due to the high costs of malpractice insurance. And the current administration's policy of containing medical cost by further reducing physician reimbursements is guaranteed to drive out even more.

This trend is a growing problem.[97] It is costly as well. One result is that more patient care takes place in emergency rooms and hospital outpatient services, which are relatively more costly, than in doctors offices. Low physician reimbursement levels also create a disincentive for obstetricians to provide preventive services and for other physicians to care for high-risk poor children with multiple problems, thereby forcing the children with the highest medical needs into the lowest-quality health-care services. Unless reimbursement rates are raised and automatically adjusted for inflation, such harmful trends will continue.

California is at the forefront of a major shift in the financing of health care—both private and public. In 1983, dramatic changes in the MediCal system, causing cutbacks in service and coverage, placed even greater burdens on counties to provide necessary health care services. Virtually every week a new health plan springs up in the private sector, and the state has over the past several years experimented with a variety of different mechanisms for paying providers under the MediCal program. For

TABLE 8-19 Major Payers of Children's Health Services in California

Payor	Services Provided	Eligible Groups	Number Served	Administered By	Estimated Costs
Department of Developmental Services	Comprehensive package of services: social, financial medical, and rehabilitative	Any developmentally disabled person, including mentally retarded, cerebral palsied, epileptic, and autistic	*1986–87:* 36,993 (under 21)	State, which contracts with Regional Centers and State Hospitals	*1986–87:* $870 million (incl. adults)
California Children's Services	Diagnostic evaluation, school-based therapy, case management, and for medical care by authorized providers	Physically handicapped children with family adjusted gross incomes below $40,000	*1985–86:* 64,276	State Dept. of Health Services and regional offices	*1986–87:* $50 million
Maternal and Child Health	Prevention programs supporting family life and child health	Eligibility based on membership in target group, for example, pregnant low-income women, high-risk infants,and teen parents	*1985–86:* 34,346	State Dept. of Health Services and local health departments	*1985–86:* $28 million
Child Health and Disability	Health assessment screenings, including health history, physical examination, immunization, vision and hearing tests. Referral for diagnosis and treatment.	MediCal-eligible people ages 0–20; low-income, non-MediCal eligibles ages 0–6	*1985–86:* 729,013	State Dept. of Health Services and local health departments	*1985–86:* $40 million
MediCal	Financial support for necessary health care for low-income groups	Recipients of AFDC or SSI, medically indigent and medically needy individuals	*1985–86:* 1,437,517	Federal and State	*1985–86:* $958 million

SOURCE: California Department of Health Services and California Department of Developmental Services.

the most part, these changes in private and public financing of health care are undertaken to save money or contain costs, with generally less regard to their effects on accessibility and the quality of care provided."[97]

More attention must be paid to ensuring that all children in California receive care that is not simply cost-effective, but also high in quality and delivered in a timely fashion in appropriate settings. This means expanding coverage to children who are currently without health insurance. It also means ensuring that provider payment levels under the MediCal program retain a rough equivalence to what providers receive from private paying patients. Finally, it means that the state must adequately monitor the proliferation and operation of new health care entities seeking to insure middle- and higher- income families.

In addition, the state should take full advantage of potential federal subsidies that would allow the expansion of MediCal services to additional mothers and children. For example, the federal 1987 Omnibus Budget Reconciliation Act permits states to expand Medicaid coverage to pregnant women and their infants (whose family income is less than 185 percent of the federal poverty level) through the first year of life. The costs of such an expansion of MediCal services would be matched by a 50 percent federal contribution.

Another measure would streamline the MediCal eligibility process. The federal 1986 Omnibus Budget Reconciliation Act (OBRA) permits qualified providers to immediately enroll pregnant women and circumvent the normal six- to eight-week process that delays the start of prenatal care. Finally, something must be done to provide the children of the near-poor and working families with access to basic health care.

Lastly, for low-income high-risk children who are afflicted with a constellation of medical, developmental, and psychosocial problems, and are living in marginally functional to dysfunctional families, additional case management services are often necessary to ensure that such children receive the services they need. The 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA) allows states to cover case management services in order to assist individuals eligible under Medicaid to gain access to needed medical, social, educational, and other services.

Conclusion

A broad survey of the state of children's health in California suggests that their health needs are complex and varied. On the bright side, the vast majority of children (over 95 percent) are reported by their parents to be in good or excellent health. The gains have been very heartening: infant mortality has greatly and steadily decreased; killer diseases of childhood have been significantly reduced and sometimes even eliminated (smallpox, for a prominent example); and less deadly but still burdensome childhood diseases such as measles, mumps, and whooping cough have been effectively addressed by immunization.

The conditions that must be considered regarding today's child health problems characteristically involve the effects of poverty, family disruption, divorce, teen parenting, developmental difficulties resulting from emotional stresses, and other disorders where no single cause is evident and no simple medical solution exists. Policies need to be directed toward the social, economic, and cultural, as well as psychological and medical causes of adverse health outcomes. It has been noted throughout this chapter that the effects of poverty are widespread and underlie or compound many of the problems facing children. The incidence of many health problems, from infant mortality to substance abuse, is significantly higher among children living in poverty.

Because of the sharp decline in the traditional causes of death and disease (particularly acute infectious diseases) among children, "new morbidities"—social, familial, developmental disturbances of children that manifest themselves in behavioral problems, poor health habits, destructive activities, and emotional disturbances—are becoming the central concern of health policy for children. The nature of these changing conditions and emerging issues calls for a more integrated, more inclusive child health policy. Such a policy would address the complexities of social and individual conditions that account for the new patterns of child health problems that California faces today and that will affect the health and well-being of tomorrow's adults.

This chapter presents the current condition of child health and California child health programs, beginning with a review of infant dealth and illness. The sharp decline of infant mortality over the past century has been striking. It is also striking that in California in 1985, the infant mortality rate actually rose, the first time such a rise was recorded. Preventable infant deaths are concentrated among poor minority populations, and can be attributed in large part to the relatively high numbers of pregnant women from such disadvantaged groups who do not receive early, continuous, and high-quality prenatal care. California, which recently ranked tenth, now ranks twenty-seventh among states in the proportion of pregnant women receiving prenatal care in their first trimester of pregnancy.

Access to comprehensive prenatal care is a key factor in reducing the relatively high incidence of infant mortality and morbidity. Poverty diminishes access to prenatal care. Even when eligible for MediCal-financed prenatal care, most MediCal recipients do not receive care early and continuously. The very low levels of reimbursement for physicians providing prenatal and maternity care limits the number of available providers. In addition, continuity of care is affected by lack of information, outreach, and knowledge about the importance and availability of care. For near-poor women, who are not eligible for MediCal, paying for care is often impossible. Since the prevention of infant mortality and morbidity is firmly connected to adequate prenatal care, providing such care to low-income expectant mothers may be the single most effective way to prevent potentially devastating sequelae of prematurity. We must alter conditions that discourage obstetricians from participating in publicly financed care for the needy.

Marked shifts over the past half-century have occurred in the causes of death for children after the special dangers of the newborn and infancy period. As deaths due to infectious diseases have declined enormously, a proportional increase has occurred in the share of child mortality resulting from unintentional injuries and violence. These so-called new morbidities are more obviously preventable. But prevention strategies directed at abuse that leads to a child's injury or the depression that results in an adolescent's suicide need to take into account the complex interactions of social, psychological, and familial aspects of the situation.

Adolescents in particular show a disturbing trend in deaths from murder, suicide, and preventable accidents. Interventions to address these problems will have to be appropriately complex, not only dealing with adolescents, but affecting the earlier childhood and family conditions that help account for later adolescent behavior.

Adolescent pregnancy is connected to a complex set of outcomes that seriously affect the babies as well as the young parents. Many teen pregnancies result in situations in which teen mothers require extensive welfare support. In California, over half of AFDC payments go to mothers who gave birth as teenagers. Many of the children born to teen mothers grow up in poverty; of all families with children age 5 or younger headed by mothers who gave birth as teenagers, 67 percent have incomes below the poverty line. Few of these teen mothers are able to develop stable family lives and often must rely on an array of expensive public services.

Programs that work with teen mothers and fathers—early prenatal care, parent training, and child care at the school site to help young mothers stay in school—have been shown to be effective and should be expanded. Prevention of unintended teen pregnancy has been demonstrated to be a cost-effective strategy. Preventive approaches must look to the social condition and cultural experience under which teen pregnancies occur. Important ingredients are the self-esteem and life prospects of the young women who become pregnant. Although knowledge about contraception and the availability of family planning services are important, early intervention programs (such as Head Start, family support projects, dropout prevention projects, and the like) that effectively change children's or adolescent's views of themselves and their future life options can contribute valuably to teen pregnancy prevention. Promoting positive attitudes and expectations can provide strong incentives to avoid pregnancy.

In the area of prevention services, the major state program is the Child Health Disability Prevention Program (CHDP), one of the most ambitious preventive health programs in the nation. By providing public support for early periodic screening, the program encourages early identification of developing conditions leading to health problems in order to enable treatment before more serious consequences develop. Reaching the potential clientele for widespread effective prevention has been a problem for the CHDP program. Although the program has expanded, in 1983–84 CHDP provided services to only 22 percent of eligible individuals. Not only should the program be made available to those now eligible, but services should be expanded and greater attention paid to the changing profile of "new morbidities." With the growing problems of adolescent pregnancy, teen suicide, violence, and a variety of serious mental health problems, an expansion of CHDP should be geared to adolescents. The potential flexibility in the CHDP program and the ability to actively provide case management services and use schools as centers for care endow this program with the capabilities to address the health needs of a large number of adolescents. To increase effectiveness, the mental health dimensions of the screening program need further development. In addition, in the years since the guidelines for CHDP were originally formulated, groups with special health needs that deserve special attention by the CHDP program have emerged. These include high-risk infants, foster children, drug-exposed babies, and homeless children.

California Children's Services (CCS) has been generally successful in its long history. This state and federal program originally targeted crippled children, expanding later to include services to chronically ill children such as those suffering from sickle cell disease and cystic fibrosis. As the profile of chronic illness has changed from largely orthopedic conditions resulting from polio and other physically disabling diseases, the types of conditions treated by CCS providers have changed accordingly. Unfortunately, the number and needs of chronically ill children in California appear to be increasing faster than the funding of CCS; increases in state support for the program are needed to prevent future rationing of services.

The state immunization program has been very successful and has shown steady gains each year as new policies and procedures are implemented. The importance of immunizations and vaccines cannot be overemphasized; their widespread use has effectively eliminated many killing and disabling diseases. Although gaps still exist for toddlers, by the time children enter school, most are completely immunized.

Although the Department of Developmental Services (DDS) serves a smaller number of children than CHDP or CCS, the number of children needing coordinated developmental services is growing. Through its system of regional centers, this program organizes and provides a complex set of services designed to promote optimal function and permit children to grow and develop in the least restrictive environments. As the number of high-risk infants increases as a result of prematurity, drug exposure, or abuse and neglect, this program will need to improve case finding and outreach; it will also need to provide additional services. The coordinations of the efforts of DDS, CHDP, CCS, MCH, and special education programs offered through the Department of Education is another mechanism to encourage policies that enable high-risk infants to receive the continued support they need.

Health care financing for children is a complex and varied subject. Most children are covered by parental employee-based health insurance plans; some children are covered by individual private health insurance; and others are covered through public insurance for the poor and medically indigent in the form of MediCal. Recent data show that between 19 and 23 percent of children in California have no health insurance whatsoever. These uninsured children are mainly in the "near poor" category, an income level too high to qualify for MediCal but low enough to make private health insurance a serious financial burden. Children living in "near poor" families often have two parents with jobs that do not provide health benefits.

Approximately 17 percent of California children are covered by MediCal. Although mothers and children represent the majority of MediCal beneficiaries, they account for only about a quarter of MediCal expenses. By far the most important sources of rising MediCal costs are the populations of elderly and disabled Californians. Besides eliminating remaining eligibility barriers to MediCal, there is the growing problem of decreasing provider reimbursements relative to customary fees. These shrinking reimbursement rates create incentives that are responsible for the unwillingness of obstetricians and pediatricians to provide MediCal services. This tendency aggravates already existing difficulties of providing MediCal services wherever and whenever needed. It is more than ironic that the women and children with greatest health care need are often systematically excluded from the type of services that they need most.

Looking Ahead: A Framework for Future Policy Considerations

A theme that emerges in this chapter is that many of the historical causes of infant and childhood death and disease have been addressed or overcome, and that the major challenges today are developmental disabilities, learning problems, child abuse, drug and alcohol abuse, teen pregnancy, family violence, and accidents. These conditions are by no means new, but they have replaced infectious diseases as the major causes of child mortality and morbidity. Children experiencing these conditions are often poor and living in families with other children who have multiple health problems. The complexity of the problems demands strategies for prevention and treatment that are comprehensive and multidimensional. They must address medical, developmental, familial, and social conditions over the long term, taking into account the entire life course of these vulnerable children.

These new morbidities and their complex causes underline the importance of a developmental perspective toward health. Behavioral and mental health problems begin early in life. Key psychological processes that shape the child's future life course occur during the first two years of life. The desirable experience of firm and loving attachment to parental figures takes place in nurturing, supportive home environments. Unfortunately, many children are born into disruptive, chaotic, stressful homes that can seriously disturb important processes of emotional development. Babies born to teenage mothers, drug and alcohol users, or mentally disturbed parents are especially at risk for these disturbances. As noted earlier, the conditions of poverty, the dislocations of migration, and other culturally related issues also contribute to undermining the support and nurturing necessary for healthy childhood.

More programs that address the important interconnections between successful human development and mental and physical health are needed. Such programs would include parental education, infant stimulation, mental health home visitations, nutrition and educational supports for primary health care for mothers and infants, and family support services such as parent-child centers and family resource programs. These programs should be geared toward supporting and building the family and should be integrated with such educational programs as Head Start, as well as preventive health services such as the CHDP program.

Sustaining this network of interconnected support services into the school years is also important. A great deal of attention has focused on the vulnerabilities of infants and toddlers and the growing problems of adolescents. In between these two groups are elementary school children who have their own important needs. These needs include the early identification and remediation of learning disabilities, behavioral problems, accident prevention, and after-school care. In addition, even at this young age, effective programs aimed at preventing drug and alcohol abuse, school failure, and delinquency can be implemented.

Adolescents face a wide range of difficult issues as they make the transition from dependency and vulnerablility to full functioning as independent adults. Adolescents may feel they have no options and are powerless to determine what happens to them. As a result, they may fail to acquire the skills and knowledge they need to function as adults. Psychological issues ranging from a lack of self-esteem to serious mental illness may make it difficult for young people to steer a straight course. Drug and alcohol abuse, early pregnancy, and adolescent behavior that increase chances of violence and accidents are also issues that social policy has not adequately addressed. Compounding these problems is the inadequate access of the most at-risk groups to medical and mental health services. Providing a comprensive set of culturally appropriate diagnostic, treatment, preventive, and rehabilitative services must be a major policy imperative. Programs aimed at preventing teen pregnancy and drug and alcohol abuse should be coordinated with primary medical, mental health, and case management services to fill the holes in the supportive nets for these youths.

This chapter points to several important directions for new policies. First, the changing condition of children in California resulting from demographic changes, increased poverty, and the greater incidence of developmental, emotional, and behavioral disturbances creates a need for new strategies. Such strategies should include greater emphasis on comprehensive preventive health, mental health, and education programs for infants and toddlers. For programs to be truly comprehensive, they must not only provide early identification services, but must also identify and address risk factors which increased the likelihood that a condition will develop. These strategies should also include health, education, and family support services for poor children, and a case management approach should be used to assure integration and the elimination of service gaps. Such services should be mandatory entitlements for all children entering the child welfare system.

Second, existing programs should be modified and expanded to include a developmental perspective. For example, teenage pregnancy prevention programs begun during the teenage years are not highly effective. Such prevention efforts should begin during preteen years and should address such issues as low self-esteem, educational failure, and a sense of hopelessness.

Third, services should be integrated and bureaucratic fragmentation should be overcome. Needy children and families are confronted with a seemingly disjointed set of services offered by different agencies in different locales. Not only is integration and coordination needed on an individual client level, but greater coordination and integration is needed at the county and state agency level. There are 160 programs in California that directly or indirectly relate to the health and welfare of children. These programs are distributed among seven departments and thirty-five state agencies. Coordination among the programs at the state and county levels must be improved.

Finally, there is the issue of access. The poor and near-poor do not get the comprehensive health care they need. Programs do not find all or even most of those eligible for their services. Fragmented programs further discourage those who need health care by creating artificial, bureaucratic barriers. Compounding the existing access problem are the cost-cutting measures imposed on MediCal during the past several years, coupled with increased competition in the health care market place that discourages providers from caring for poor children, especially when these children have multiple problems and multiple risks. These trends make it difficult simply to maintain current levels of health care for the poor and the indigent, let alone raise those still inadequate levels.

Our children's health is precious. It is important for its own sake and for the future of society. Assuring the health of today's children is the greatest investment a state can make.

Chapter 9

Mental Health

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Many people were helpful to us as we prepared this chapter, providing us with information and observations from their work with children. We acknowledge as well the helpful assistance of Eligio Vella, Kathy Styce adn Sara Gilb of the State Department of Mental Health who provided us with data from the Client Data System. We received helpful comments on an earlier draft of this chapter from Jamie Halpern, Pat Jordan, Paul Newacheck, Sue North, Larry Platt, Herb Schreier, and Laurie Soman. Finally, many thanks also to Mohini Singh and Ellen Bernstein of the CVC who typed many versions of the chapter.

This chapter surveys children's mental health conditions in California. First, we briefly describe the concept of "mental health" and current classifications of illnesses and disorders. Then we evaluate the prevalence of mental illness and the risk factors associated with mental health problems in children, and summarize the range and availability of mental health services for children. Finally, we describe current public policy initiatives in the mental health arena, paying special attention to the growing numbers of children at high risk for problems resulting from social conditions associated with poverty.

The appropriate goals of mental health services reach beyond the direct treatment of manifest disorders to include the identification of conditions that predispose children to future troubles. Such conditions are referred to in public health literature as "risk factors." Risk factors are conditions or aspects of an environment that have been shown to have a higher association with an undesirable health outcome than is the norm for the relevant population. Of course, presence of a "risk factor" does not mean that all or even many of the individuals characterized by the factor *will* develop the associated outcome. As noted later in this chapter, rapidly changing social conditions have dramatically affected the range of cultural and familial situations that create risk factors for children's mental health problems.

Adequate understanding of the human psyche, how it works and what causes its disorders, is still a long way off. With respect to children, it is known that changing family structures, economic hardship, genetic and biological factors, the psychodynamics of "dysfunctional" families, and other conditions contribute to the stresses and challenges predisposing individuals to a wide range of psychological troubles. But identification and diagnosis, as well as treatment and evaluation of treatment efficacy, are still highly interpretive and uncertain activities in the field of mental health, much more so than in those areas of medical science that do not involve the uniquely difficult subject of minds and emotions, characters and personalities, values and intentions.

A theme that is emphasized throughout this chapter is the importance of families in both the genesis and resolution of mental health problems. Even in cases in which the mental health problem has a strong biological or genetic etiology, and is amenable to pharmacologic treatment, the family's role in on-going support and after-care is crucial. In many instances, the role of family dynamics and resources is central to both the development and potential resolution of the child's difficulty. The complexity of these problems cannot be addressed by a single drug but necessitate comprehensive family-based interventions. Another theme that emerges is the need for greater emphasis on prevention and early identification services.

This chapter describes the current situation (while expressing only modest claims about data), discusses theory and treatment ideas, and describes the caregiving capabilities of the various state mental health programs. This presentation can serve as a useful basis for devising appropriate, concrete, and effective policies to enhance the most important resource any society can have— the well-being of its children.

Diagnosis and Statistics

The naming and classification of mental health problems is an important and difficult process. A specific psychiatric diagnosis often determines the type of treatment needed, and where that treatment should be received. The diagnosis may also be made for purposes of reimbursement. However, because many mental health problems represent behavioral responses to highly dysfunctional and unsupportive family and environmental influences, labeling a child with a psychiatric diagnosis can often be a two-edged sword; the diagnosis may enable the child to receive needed services, but attributing certain characteristics to the child and family (labeling) can sometimes become a self-fulfilling prophecy. Psychiatric diagnosis of children involves several interrelated parts: classifying and organizing diagnoses by type and severity; the actual diagnostic process, such as the questions that must be answered to arrive at a diagnosis; and the instruments available to answer those questions, such as interviews, rating scales, psychological tests.[1] The next section discusses classification in order to describe the impact of mental health problems and their prevalence in childhood.

The most widely used nomenclature in the United States for mental disorder is presented in the *Diagnostic and Statistical Manual of Mental Disorders* by the American Psychiatric Association.[2] Definitions of disorders are generally limited to clinical features. The third edition (1987) was recently revised (*DSM-III-R*) to clarify and specify criteria for several classifications, including some relevant to children. According to the *DSM-III-R* definition, mental disorder is:

> A clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable response to a particular event.[3]

A recent report published by the Congressional Office of Technology Assessment, entitled *Children's Mental Health: Problems and Services*,[4] distinguishes between a "mental health disorder" and the more inclusive "mental health problem." A mental health problem is defined as "either a mental disorder or a more general subclinical problem affecting mental health but not meeting the criteria for a diagnosable mental disorder." This distinction draws attention to the importance of early identification and prevention of behavioral symptoms that may prevent these symptoms from progressing to diagnosable mental disorders.

The *DSM-III-R* divides disorders of infancy, childhood, or adolescence into five general categories based on shared clinical features, and provides specific diagnostic criteria. These general categories of emotional, social, and conduct disorders are described in Appendix 9-1.

Developing Estimates of Need

Estimates of need are most accurate and informative if based on prevalence data (that is, data on frequency of different types of problems, age of onset, and severity at a given time). Accurate prevalence estimates require data describing the distribution of mental health problems in the child and adolescent population.

Service-Based Estimates of Need

Service use data can be used to construct estimates of need in the absence of more valid prevalence data. Unfortunately, the only data available to estimate prevalence of mental health disorders in California are very limited service data from public mental health agencies. Public mental health agencies are required to report the number of "open cases," that is, the number of childen being served currently in the public mental health system. These data can be used (with great caution) to estimate the prevalence of mental health problems. However, most children do not receive services in the public mental health system, but rather from private providers. In addition, service data are likely to underestimate the less severe conditions, especially if there are any barriers to access. Children with severe problems are more likely to receive services, and are thus more likely to be represented in the service data. We will describe two examples of service-based estimates of mental health need, the first based on number of individual clients served, the second based on reported service episodes.

In 1987, the University of California collected general information for a mandated report to the legislature. Data were gathered from state agencies on the number of children receiving mental health, special education, or developmental services, and the number of children who were at risk because they were in foster care or the juvenile justice system (Table 9-1). The total population receiving services, including children served by the education, social services, and juvenile justice systems, as well as the mental health system, exceeds 700,000. These figures provide only a very rough estimate of the number of children presumed to be receiving some type of mental health services in California. According to the University of California report, needs assessments carried out in several counties as mandated by recent legislation[5] found that only about one-third of children identified as needing mental health services was actually receiving them. Another inherent limitation in estimating need by combining "open case" counts across agencies is that it can produce duplicate counts: individual children served by several agencies are counted several times.

It is difficult to estimate the exact number of children in education or juvenile justice programs who receive mental health services. The number of children in out-of-home placement in California is estimated to be approximately 59,000 (Table 9-2). These placements include foster care, county mental health programs, residential programs for the seriously emotionally disturbed, drug programs, programs for pregnant teenagers, and alcohol treatment programs.

The Client Data System

The California legislature's budget bill of 1983-84 established a statewide database (Welfare and Institutions Code 5656) to answer several specific questions about mental health service use:

1. What are the demographic characteristics of children being served by the public mental health system?
2. How many children are being served?
3. What are the sources of payment for services?
4. What types of services are provided?
5. What types of problems are treated?
6. What are the legal statutes under which services are provided?

In addition, this database is intended to associate costs with types of services and with client characteristics. Beginning with fiscal year 1985-86, counties were required to submit data to the Client Data System (CDS). As implemented, the CDS is a statewide database of *episodes of service*, not of individuals served. Thus, the information describes specific services provided and does not furnish information about the use of services by particular individuals.

Summary data from the Client Data System for fiscal year 1986-87 indicate that service episodes for the child population (up through age 17) accounted for approximately 17.5 percent of all mental health service episodes. Table 9-3 presents a breakdown of fiscal year 1986-87 service episodes by age and sex. Less than 10 percent of service episodes involved preschool children. Boys are more frequently served than are girls. Table 9-4 compares ethnic distribution for the state overall, the state foster care system, and the CDS. The Hispanic population is somewhat underrepresented, and the black population is overrepresented in both foster care and mental health services represented by the CDS.

Table 9-5 presents the distribution of fiscal year 1986-87 service episodes by *DSM* categories. The five categories of mental disorder usually first evident in infancy, childhood, or adolescence account for approximately 39 percent of all service episodes. Behavior disorders and emotional disorders occur most frequently.

The other categories of mental disorder, primarily adult disorders that may occur among children, account for nearly 55 percent of all service episodes. Within these twelve categories, mood disorders and adjustment disorders are most prevalent.

TABLE 9-1 Children Served by Selected California State Agencies

	Number Served
Department of Mental Health—1983–84	
Episodes of Service	40,000
Admissions to State Hospitals	430
Department of Developmental Services—1985–86[a]	
Active clients	
Ages 0–4	7,600
Ages 5–17	17,500
Ages 18–21	7,200
Department of Education—1986	
All Special Education Programs	397,240
Programs for Seriously Emotionally Disturbed	9,632
Department of Social Services—1985	
Emergency Responses Services	
All cases	295,769
Sexual abuse cases	54,121
Physical abuse cases	86,694
Dependent (Foster) Care[a]	32,000
California Youth Authority—1986[a]	
In institutions	5,000
On parole	3,000
First admissions per year	2,200–2,300
Department of Alcohol and Drug Abuse—1985–86	
Drug AbuseTreatment Program	4,074
Alcohol Abuse Treatment Program	16,000

[a] approximate figure

SOURCE: University of California, Report to the Legislature, 1987.

TABLE 9-2 Children in Placement

AFDC–FC Foster Care—(May 1987) 36,692 supervised by county welfare departments 5,003 supervised by county probation departments	41,695
California Youth Authority—(September 14, 1987) 100 children were placed in CYA certified/approved homes.	8,588
Emergency Shelter Care—(May of 1987)	4,107
County Probation—(November 1986) An unknown number of children are served in county juvenile halls.	3,223
State Mental Health—Beds available in State Hospitals	315
Short Doyle (County Mental Health Programs)	150
Severely Emotionally Disturbed (AB 3632–P.L. 94–142) May 1987, with projections for approximately 800 by June 30, 1988.	154
Seriously Emotionally Disturbed (Budget Act of 1980) Placed in three regional programs for seriously emotionally disturbed children.	48
Pregnancy Freedom of Choice Act (AB 1069) Admissions per year into 7 contracted facilities, serving pregnant unmarried persons under 21.	618
Drug Programs (Fiscal Year 1985–86) 480 children in placement	480
Private Psychiatric Hospitals	unknown
Alcohol Programs Total number of children are unknown; however, approximately 6 waivers per month are granted to adult alcohol recovery facilities which permit them to accept children and two programs with a total capacity of 42 serve women with children.	
TOTAL	59,378

SOURCE: State Department of Mental Health, 1987.

In *DSM* classifications, severity of disturbance is reflected by both a diagnosis and a rating for level of functioning. The distribution of scores on the Global Assessment of Functioning Scale from the Client Data System indicates that of all service episodes during fiscal year 1986–87, approximately 4 to 5 percent of service episodes involved children or adolescents who were judged to be at a level of impairment in social or psychological functioning described as "very poor" or "grossly impaired."

Estimating Need Based on National Prevalence Figures

Another way of estimating prevalence of mental health problems and need for services is to extrapolate from national estimates to the state level. National prevalence estimates of occurrences of children's mental health problems range from 5 to 15 percent of the population. A recent review of twenty-five studies concluded that "the prevalence of clinical maladjustment in the U.S. is probably no lower than 11.8%."[6] According to the 1987 census data, there are approximately 7 million children and adolescents under age 18 in California. Applying national epidemiological estimates to California's population of children and youth generates the range of need estimates shown in Table 9-6.

These figures represent the population of children estimated to be in need of mental health services. However, such estimates do not take into account the severity of disturbance and level of care needed– knowledge that is needed for policy formation.

Several sources have estimated the national prevalence of severe emotional disturbance in children and adolescents. The range in estimates reflects a lack of consensus regarding the definition of "severely emotionally disturbed" for children and adolescents.[7] Applying these national estimates to California yields Table 9-7, which shows the range of estimates for severe emotional disturbance in the California's child and youth population.

TABLE 9-3 Client Data System, Service Episodes Involving Children 17 and Under, FY 1986–87[a]

	Number	Percent
Age		
0–5	7,472	9.7%
6–11	25,033	32.7
12–17	44,147	57.6
Sex		
Female	31,282	40.8
Male	45,230	59.0
Unknown	140	0.2

[a] Episodes of service for FY1986–87 totalled 439,679. The 0–17 age group accounted for approximately 17.5 percent of all service episodes.

TABLE 9-4 Distribution by Ethnicity in the State, in Foster Care, and in the Client Data System[a]

	State Overall Age 0–17[b]	State Foster Care[c]	CDS Receiving Services[d]
White	52.1%	43.0%	56.1%
Hispanic	30.7	20.0	21.1
Black	9.0	32.0	15.9
Asian			1.9
Native American			0.6
Filipino	[8.2]	[3.5]	0.5 [7.0]
Other			1.6
Unknown			2.3
			0.1

[a] Total California Child Population (Ages 0–17) = 7,100,000 in 1987 (from CASSP).

[b] Total 6,850,307, Dept. of Finance Project.

[c] As of May 1987.

[d] Fiscal Year 1986–87.

TABLE 9-5 Distribution of Service Episodes Across *DSM–III–R* Categories

	Number	Percent
Developmental Disorders		
Intellectual	321	0.6%
Behavioral*	12,065	22.9
Emotional	6,573	12.5
Physical	586	1.1
Developmental	860	1.6
Subtotal	20,405	38.7
Other DMS/ICD Disorders		
Organic	417	0.8
Substance Use	339	0.6
Schizophrenic	657	1.2
Schizopheniform	886	1.7
Mood (Affective)	6,083	11.5
Anxiety	2,680	5.1
Somatoform	49	0.09
Psychosexual	105	0.2
Factitious	3	—
Disorders not elsewhere classified	269	0.5
Adjustment disorder	17,140	32.5
Personality disorder	386	0.7
Subtotal	30,491	54.8
	missing data	6.5
		100.0

* Conduct disorder 16.1%

According to 1986 data from the State Department of Education, fewer than 10,000 children and adolescents in California's public school system have been identified as severely emotionally disturbed. The disparity between the number as predicted from national estimates of emotionally disturbed children and the actual number receiving special education services in California's public schools suggests a significant gap between the number of children in California estimated to be in need of mental health services and the actual number receiving services.

Social and Environmental Risk Factors

Because so often mental health problems among children are regarded as resulting from genetic, biological, or organic causes, it is important to recognize the impact of the family and social environment on the child. In recognition of the role of environment, on Axis IV of the *DSM III*, Severity of Psychosocial Stressors, certain environmental stressors are cited as potentially significant contributors to mental health disorders. These stressors include, for example, anomalous family situations such as single parents or foster families, school or legal problems, and unwanted pregnancies.

TABLE 9-6 Estimates of Children's Need for Mental Health Services in California Based on National Prevalence Rates

Source		Rate	Number of Children (Estimate)
1978	President's Commission*	5.0%	355,000
		15.0	1,065,000
1969	Joint Commission on Mental Health of Children	13.6	965,600
1981	Gould, et al.	11.8	837,800

* The two estimates shown represent the range reported in this report.

Since children's mental health is defined broadly to include emotional and behavioral problems such as anxiety and conduct disorders (Appendix 9-1), the family and social environment may have, if not a directly causative effect, certainly either an exacerbating or ameliorative impact. This impact is important in its implications for prevention and early intervention efforts as well as for treatment of diagnosed mental health problems.

A number of family and environmental situations have been identified as potentially of high risk to the development of mental health problems in children.[8] While each of these situations can be examined separately, recently the focus has shifted to the child's vulnerability or resiliency and his or her ability to negotiate any context of risk.[9] Speaking of psychosocial resilience, Michael Rutter says, "Protection in this case resides, not in the evasion of the risk, but in successful engagement with it."

With this understanding in mind, the following discussion reports some of the more common risk situations in a child's environment. We do not mean to suggest that only children from such situations become mentally ill, or that all children with such risks do. Prevalence figures on children's mental health problems indicate that they occur widely in the population. Nevertheless, understanding the potential risks of these situations may enhance our ability both to identify children early in the development of a problem, and to create preventive and therapeutic approaches that recognize the importance of family and social factors.

TABLE 9-7 Estimates of Severe Emotional Disturbance in California Children Based on National Prevalence Rates

Source		Rate	Numbers of Cases (Estimate)
1980	National Plan for the Chronically Mentally Ill	8%	568,000
1982	Knitzer/CDF	5	355,000
1987	Friedman	2	142,000

Socioeconomic Disadvantage

Persistent urban poverty is associated with a variety of conditions that may put children and families at risk for mental health problems.[10] For example, poverty is often associated with single-parent families, poor access to health care resources, teenage parents, dysfunctional families, inadequate nutrition, drug use and abuse, crowded living conditions, inadequate social support, and pervasive environmental stress. Children from such stressful environments may demonstrate a variety of developmental, emotional, and behavioral problems. How the characteristics of the child and environment interact may depend on the quality of relationships in the home. The complex interactions among these factors must be considered in the attempt to diagnose or treat a mental health problem in the child.

Disadvantaged children often suffer from inadequate access to health care resources. Services to improve the health and mental health conditions of these children may not be available. For example, there are approximately 20,000–25,000 runaway or homeless youth in California on any given day, few of whom have access to health services. Children under age 18 are the fastest growing subgroup in the homeless population. A recent report estimated that one out of seven children in California public schools is a recent immigrant[11] who may not have access to mental health services because of cultural and language barriers as well as immigration status that makes him or her ineligible for Medi-Cal coverage.

Foster Care Placement

Approximately 50,000 children are currently placed in foster care in California. The prevalence of emotional, behavioral, and developmental problems among children in foster care has been well documented. Numerous studies report that between 30 and 80 percent of foster children examined for psychological problems are moderately to severely impaired. Although many of these children's problems precede and possibly precipitate placement in foster care, the disruption of out-of-home placement itself can cause an adjustment reaction and long-term emotional and behavioral problems.[12]

Abuse and Neglect

Risks to children's mental health result from several kinds of child abuse, including physical abuse, sexual abuse, emotional abuse, and neglect. Reports of child abuse have been increasing dramatically in California, as elsewhere. Child abuse reports increased by 51.9 percent between 1981 and 1985 in California.[13]

Most abused children come from highly stressed families with multiple problems, such as poverty, unemployment, and lack of education. Patterns of child abuse also appear to be perpetuated intergenerationally.[14]

Most children experience more than one type of maltreatment. Emotional abuse is increasingly recognized as causing the child to experience low self-esteem, fear, anxiety, and other psychological damage. Sexual abuse of children results in long-term serious psychological effects.[15]

Neglected and abused children are believed to be at much higher risk for developmental and behavioral problems than are other children. Neglect in early infancy in particular can result in failure to provide the child the opportunity to form a secure attachment relationship, with subsequent difficulties in social and emotional development.[16]

Parental Psychopathology

The vulnerability of a child to damage from a relationship with a mentally ill parent depends on the degree of contact, involvement, and identification with the parent. The child's own susceptibility to parental influence is also a factor.[17] In some conditions, a genetic factor may place the child at risk for developing the same mental disorder suffered by the parent. Parental psychopathology can take any number of forms. Some major types include parental substance abuse, affective disorder, and schizophrenia.

Substance Abuse. National estimates of the number of children with an alcoholic parent range from 12 to 28 million. Comparable figures on the number of children in California with an alcoholic parent are not available; however, there are about 1 million problem drinkers in the state.[18] Parents abusing other substances are fewer in number, although polydrug use with alcohol often occurs. The effects of parental substance abuse on children have been widely documented. The children demonstrate many behavioral problems, such as acting out and aggression, and emotional difficulties including depression, suicidal thoughts and actions, repression, and poor self-esteem.[19] Such children often live in family environments that are undisciplined, chaotic, and confusing. In addition, substance abuse problems in the family may be associated with conflict, violence, spousal abuse, and child abuse and neglect, as well as parental separations and divorce.

Affective Disorders. Affective disorders are far less common than alcohol problems. Nonetheless, as many as 40 percent of children of parents with affective disorders, including depression and manic-depression, may exhibit similar illnesses, either in childhood or later. The interplay between possible genetic predisposition to these disorders and environmental risk factors is little understood. In particular, depression is common in mothers of young children.

Children of depressed mothers often exhibit depression, separation anxiety, attention deficit disorder, personality disturbances, and conduct disorders.[20]

Schizophrenia. Schizophrenia in a parent is also quite rare compared to alcohol problems. Parental schizophrenia places children at very high risk for developing mental disorder. The child's risk of developing schizophrenia is ten times that of children of nonschizophrenic parents, although as few as 10 percent of children of schizophrenics become schizophrenic themselves. This risk factor is usually embedded in other risks; for example, schizophrenic mothers usually live in poor circumstances and have received poor prenatal care.[21]

Problems of Adolescence

Adolescents are often at risk for emotional difficulties, substance abuse, school failure, delinquency, sexually transmitted diseases, and unintended pregnancies.

Substance Abuse. Adolescent use of alcohol and illegal drugs can lead to physiological, behavioral, and emotional problems. National figures show that by the time they are seniors in high school, 90 percent of all children have tried alcohol and 50 percent drink daily. Sixty percent have used marijuana at least once.[22] With the exception of cocaine use, alcohol and drug use among adolescents nationwide has been gradually declining since 1980, but the proportion using alcohol compared to other drugs is still very high.[23]

Adolescent Suicide. Suicide is presently the third leading cause of death among 15- to 24-year-olds. It usually occurs in a chaotic family and may be consequent on separation or divorce of parents, abuse or aggression in the family, alcohol problems or mental illness of a parent, or suicide by another family member.[24]

Eating Disorders. Concern with physical appearance may become exaggerated during adolescence and result in the conditions of anorexia nervosa or bulimia. Both occur more frequently in female than male adolescents. Anorexia nervosa occurs in approximately 1 in 250 females aged 12 to 18. Diagnostic criteria for anorexia nervosa include rapid reduction of 25 percent or more in weight, extreme anxiety about becoming fat, disturbed body image, unusual food-related behavior (such as hoarding), excessive exercise, and denial of the disorder. Bulimia involves alternate binge and purge episodes, fear of not being able to stop eating, depression, low self-esteem, and feelings of abnormality. The prevalence of this condition is about 7.7 percent among high school girls.[25]

Anorexia appears to be associated with family and personality problems, sexual conflicts, achievement demands, and overly idealized body type. Families of anorexics have been found to be overly protective, with a tendency to use the child as a means of redirecting or hiding parental conflicts. Families of bulimics have been found to be disorganized and ambivalent, alternately caring for and abandoning the child.[26]

Prenatal and Perinatal Factors

Some of the genetic factors contributing to child development are not yet fully understood. Emotional disorders such as schizophrenia and manic-depression appear to be genetically influenced. Pre- and perinatal factors affecting child mental health and development include maternal malnutrition, poor prenatal care, illness, and alcohol and drug use. Premature birth (gestational age of less than thirty-seven weeks) and low birth weight are associated with a greater incidence of developmental disorders, but these conditions may be related to other risk factors, such as disadvantaged socioeconomic environment.

Ten percent of all babies in California each year are born to women who drink alcohol. Alcohol use in pregnancy can lead to mental retardation and fetal alcohol syndrome in offspring. Annually in California, 4,032 births occur with alcohol-related birth defects, 402 of which are diagnosed as fetal alcohol syndrome. An increasing number of babies are being born to women who are using other drugs, particularly crack and cocaine. The exposure to drugs *in utero* is related to a variety of poor outcomes for infants, including developmental delays and attention problems.

Chronic Physical Illness

Major chronic physical illnesses are affecting more children today because improvements in medical treatment have meant the survival of children who would have died in the past.[27] Children with chronic illness are three to five times more likely than other children to experience emotional problems. Chronic illness in children has a broad etiology, ranging from inherited conditions through a variety of illnesses and injuries. In all cases, the child must adapt to the limitations and discomforts of chronic illness. They experience fear and anxiety about the nature of the illness and its implications, and react to the stress of constant pain, physical limitations, prolonged confinement in bed, and the pain and discomfort of diagnosis and treatment. These children are often depressed, anxious, irritable, and withdrawn, and can regress to earlier stages of behavior. Nevertheless, what appears as maladaptive functioning in these children may actually be appropriate coping behavior.[28]

Mental Health Services for Children

This section describes preventive services, diagnostic and assessment services, treatment services, and rehabilitation services. Historically, both public and private mental health services have been largely targeted at the problems of severely emotionally disturbed children.[29] Public policy has not been targeted at establishing a continuum of mental health services to meet the continuum of need. A wide range of preventive and diagnostic mental health services are provided to children outside what is traditionally considered the mental health system.

The identification of children in need of mental health services and their first point of contact with the service system is often made in schools, medical settings, and the social welfare system by people who are not mental health professionals. Physicians other than psychiatrists do the lion's share of the "mental health" work done by doctors. National Health Interview Survey (NHIS) data indicate that about 80 percent of physician contacts for children less than 18 years old take place with either pediatricians or family practitioners, and less than 1 percent of physician contacts take place with psychiatrists or child psychiatrists. California has approximately 10 percent of the child population and a rough approximation indicates that there are 26 million physician contacts per year for children less than 18 years old.[30]

Additional data from the National Ambulatory Medical Care Survey indicate that approximately 11 to 12 percent of visits to pediatricians and family practitioners by children were for psychiatric disorders.[31] If 10 percent is used as an estimate of the pediatrician and family physician visits in California that were for mental health problems, then over 2 million contacts with pediatricians and family practitioners took place in 1985 for mental health problems, whereas approximately 300,000 contacts took place with psychiatrists or child psychiatrists.

Preventive Services

Prevention can be separated into primary and secondary strategic intervention. Primary prevention strategies are aimed at decreasing the incidence of mental health problems by providing services that remove risk factors and so reduce the likelihood of problems developing. Secondary prevention is directed at early identification of problems and marshaling of services in order to reduce the impact of the problem. Of course, primary and secondary prevention services are often provided together.

Examples of primary prevention efforts include family education programs for high-risk parents and children. In the school system, primary prevention efforts may take the form of school-based information programs such as Head Start or alcohol and drug education.

An increasingly popular form of primary prevention service are family support programs, which help high-risk families develop systems of adaptive skills and form stronger support networks. These programs emphasize the quality of the parent-child interactions and promote children's social, emotional, and cognitive competence. Family support programs take a variety of forms, each directed at specific categories: new families, single-parent families, teenage families, or families with special needs. They deliver services through newsletters, home visits, and parent support groups, and are located in mental health centers, schools, churches, and drop-in centers. The programs are staffed by mental health and health professionals, educators, and community volunteers.[32]

The aim of secondary prevention programs is to identify children who have begun to show behavioral or developmental difficulties. Like primary prevention programs, secondary prevention programs include a wide variety of services.

An extensively evaluated and replicated secondary prevention program is the Primary Mental Health Project. This program is provided to children in the primary grades with learning, behavioral, conduct, and other "mental health" problems. Children receive individually based remedial efforts through teachers and other school personnel, with consultation by mental health professionals. The PMHP model has been widely disseminated, and programs have operated in over two hundred schools throughout the country.[33]

Program Efficacy

Numerous studies have documented the effectiveness of early intervention programs delivering parent training, early education and child development, and teen pregnancy prevention.[34] One of the most widely studied programs is Head Start, which has been shown clearly to benefit both children and families.[35] However, Head Start researchers have warned that it is an error to assume that an early education program alone can eliminate the effects of social and economic disadvantage.[36]

Perhaps the best-studied family support program is the Yale Child Welfare Research Program.[37] The Yale Program provided intensive interventions to impoverished families with children in the first thirty months of life. Families received a comprehensive set of services, including home visits, pediatric care, day care, developmental assessments and interventions, and psychological services as needed over a two-and-a-half-year period. Children in the Yale Program were evaluated at five-year intervals. Early evaluations showed significant improvements in language development compared to control group children. Five years after the intervention, families were shown to be living in improved socioeconomic circumstances, and children demonstrated higher IQ scores and greater school achievement than the control population. A ten-year evaluation did not demonstrate the persistence of higher IQ scores, but did show that program children had better school attendance and better social and school adjustment. A cost-benefit analysis demonstrated that, although initial costs for program children were substantial, over the long term a net savings occurred since children required many fewer school and social services than did control children.[38]

Although intensive studies like the Yale Child Welfare Research Program have been demonstrated to show favorable, cost-effective results, such interventions are often difficult to replicate. Nonetheless, the evidence from the Yale Program, the Perry School Project, and the Primary Mental Health Project all indicate the potential efficacy of early intervention programs at both the primary and secondary prevention levels.[39]

A number of primary and secondary prevention programs currently exist in California. The Infant-Parent Program (IPP) is an infant mental health program conducted by the Department of Psychiatry of the University of California, San Francisco.

Established in 1979 and located at San Francisco General Hospital, the program is an outgrowth of an innovative project begun at the University of Michigan by Selma Fraiberg.[40] Its structure and function serve as a model for the integration of infant mental health services with delivery systems already in existence in the community. The program established links with three major service delivery systems: the pediatric care system, the child protective system, and community agencies working with infants and their families. The goal of the Infant-Parent Program is to promote the mental health of infants who are at risk of abuse, neglect, and/or emotional or developmental problems as a result of conditions in their caregiving environment. The program consists of assessments and treatment of infants (up through age 3) and their families in situations involving potential or actual child abuse, neglect, disorders of attachment, and deviations in socioemotional functioning. The program serves about two hundred families each year.[41]

The Infant-Parent Program is beginning a demonstration program, funded for three years by the Stuart Foundations, to provide day care centers for infants, toddlers, and preschoolers with mental health consultation focused on child development. The immediate work of the mental health consultant is to help the caregivers develop an increased awareness and understanding of the impact and importance of their interactions with children. The preschool mental health consultation program will deliver three closely related services: (1) programmatic consultation, (2) case-centered consultation, and (3) direct services to families.

It is anticipated that in the first year the program will serve at least fifty centers or family day care homes, and that at least two hundred providers will be reached in these settings. If consultation is provided to forty large centers, approximately two thousand children will receive care influenced by the program.

The Early Childhood Mental Health Program in Contra Costa County is another example of preventive service programs. This program was founded in 1974 by a coalition of local parents and professionals who drew on their own resources plus a grant from the San Francisco Foundation to open a therapeutic nursery school. In the years since then, the program has grown with the support of Contra Costa County Mental Health and Social Services Agencies, the Richmond Community Mental Health Center, and the United Way of the Bay Area, and now offers several programs for young children and their families and for the caregivers and professionals who serve them:

- *The Infant/Parent Project.* A home-based program of treatment and support services for parents of infants up to age 2. Services include assessment, developmental guidance, psychotherapy, parent training, and support services.
- *Preschool Consultation Team.* A group providing consultation and training for preschool teachers and day care providers who need help with troubled or difficult children.' Services include assessment of individual children, case or program consultation, consultation with parents, and referral.
- *Therapeutic Nursery School (TNS).* An intensive, year-round treatment program for children aged 2 1/2 to 5 1/2 years who have social, emotional, behavioral, language, or learning difficulties. Children attend morning sessions five days per week and receive regular play therapy and developmental testing. The professional staff are trained in child development, psychodynamic theory, and special education. The staff is supplemented by supervised graduate interns and trained volunteers.

One element that most successful early intervention and prevention programs share is an ability to not only address the needs of individual at-risk children but to support each child's development within the context of his or her family's development. This important family support has been a key ingredient in the

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success of programs from Head Start to the Yale Child Welfare Program.

Diagnostic and Assessment Services

Diagnostic and assessment services play an important role in identifying specific disorders, incipient problems, and risk factors. Early identification of problems and risk factors permit the marshaling of secondary prevention and other support services that are often much more cost-effective than treatment services after the fact. Greater emphasis on the efficacious use of early diagnostic and assessment services is clearly needed, for early diagnosis is only useful when services can be applied in a timely and effective manner.

As discussed earlier, the first point of contact for many children is not with the mental health system, but with their regular health care provider or at school. Since at least 10 percent of all visits to pediatricians and family practitioners are for mental health problems, and since these practitioners have frequent contact with children and families in the first five years of life, they are in a key position to identify conditions of risk and manifest mental health problems. Nevertheless, studies have documented that pediatricians in the normal course of routine office visits do not attend to obvious mental health problems.[43]

One of the major health care screening programs in the state of California is Child Health and Disability Prevention (CHDP). CHDP provides comprehensive health care screening to children whose family income is 200 percent of the poverty level or below. Although CHDP currently reaches only a quarter of eligible children, it is an important program for systematic health monitoring. One component of the current CHDP health care screening protocol calls for the provision of a developmental assessment for children less than 6 years of age. Although such a developmental assessment could be very effective in identifying early developmental problems in children prior to school entry, it has been difficult to implement routine developmental screening as part of the CHDP protocol.

Another important point of contact for diagnostic and assessment services is the school. Many developmental, behavioral, and learning disability problems are not identified until a child enters school. The Education for All Handicapped Children Act (Public Law 94-142) requires schools to provide education for all physically and mentally handicapped children. An individualized education program specifying education-related services must be developed for each child. Although some dispute has arisen over whether education-related services include mental health treatment such as psychotherapy, there is a growing consensus that mental health treatment *is* part of the mandate for schools. In California, each school district must provide an assessment of each referred child in order to determine whether or not that child is eligible for special education services. Under Assembly Bill 3632, mental health treatments are to be provided by the mental health departments. As of April 1986, over 397,000 children of whom 9,632 were severely emotionally disturbed, were receiving special education services in California.

Service-related efforts focused on the infant population have been facilitated by the October 1986 amendments to the Education of the Handicapped Act (Public Law 99-457). The new Part H Program authorizes the U.S. Department of Education to give grants to states to help them develop and implement statewide coordinated interagency systems of comprehensive early intervention services for eligible infants, toddlers, and their families.

In California, the Department of Developmental Services issued a request for proposals to provide assistance to local planning areas for the development of systems to coordinate all existing state-mandated programs serving handicapped or at-risk infants and toddlers. Target group definitions outlined in the federal legislation include "handicapped infants and toddlers aged 0 to 36 months who need early intervention services because they either (1) are experiencing developmental delays in the areas of cognitive development, physical development, language and speech development, psychosocial development, or self-help skills; or (2) have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

A total of $13.4 million will be available to the state from October 1987 to October 1990. Of this total grant, $4.2 million is designated for local planning and coordination of the early intervention service system.

The child welfare system also represents a point of contact for early identification and assessment of children's mental health problems. In 1988, nearly 40,000 children were in foster care in California. Children who have been abused or neglected are clearly at high risk for mental health problems. In fact, it is probably a wiser policy to assume that abused and neglected children have mental problems until proven otherwise, with the burden of proof placed on the social service system rather than on the child. This approach is recommended by numerous studies that have documented that 50 to 80 percent of foster children have moderate to severely limiting mental health problems.[43] An investigation of California's foster care system indicates that early identification services do not exist and that only children with severe, debilitating mental health problems receive routine services.[44] Early diagnosis and assessment also depends on the availability of appropriate assessment instruments that can be readily used by physicians, teachers, and child welfare workers.

Treatment Services

Treatment services for mental health problems include individual psychotherapy (psychodynamic, behavioral, or cognitive), group and family therapy, milieu therapy, or drug therapy. Settings include state and county mental hospitals, private psychiatric hospitals, children's psychiatric hospitals and units, residential treatment centers, day treatment centers, and outpatient clinics.

It is beyond the scope of this report to describe each type of therapy and setting and their efficacies, but some general observations can be made. The goal of the therapeutic process is to identify clearly the nature of a child's problem and then to match the most appropriate therapeutic service (or group of services) to the most appropriate settings. This process often means that a child with severe mental health problems is removed from the presumed exacerbating environment. Ideally, the therapeutic process should provide the child with the ability to change his or her thinking or feeling and develop new skills to help him or her function when placed back in a normal environment. In the most extreme case, a child is hospitalized. Less extreme treatment settings include residential treatment facilities and day treatment. Epidemiological data indicate that the majority of children suffering from adjustment and behavioral disorders can most easily be treated in an outpatient setting through use of individual, group, or family therapy.[45]

Several studies that have evaluated various treatment settings have concluded that determination of overall program efficacy often depends on the nature of the posttreatment setting and the kinds of support services provided to the child and family. These observations highlight the importance of a continuum of services that are developmentally appropriate and address the special needs of family systems and children in transition from one environment to another.[46]

Because children with mental health problems are more likely to have medical problems and difficulties in school, and to be involved with both the child welfare and criminal justice systems, it is often in these settings that a child's problems are identified and treatment is provided. Although making definitive statements about treatment services in the mental health context is difficult, it is even more problematic to assess how well mental health services are provided by schools, physicians, and child welfare and juvenile justice systems. A large and growing number of children with multiple problems receive services from several systems at once. For example, a developmentally delayed foster child might receive family assessment, placement, and reunification services from the child welfare system; educational, psychological testing, and special education services from the school system; health monitoring and medication from the medical care system; and additional case management through the Regional Centers system. These systems often provide some form of therapy without direct contact with mental health professionals.

The child welfare system is another example of how the system's routine functioning can have profound implications for children's mental health. Children entering the child welfare system not only suffer from the trauma of separation from their original families, but many have been traumatized physically, sexually, and/or psychologically by their biological families. Unfortunately, most children are not placed in environments capable of providing appropriate psychological support. Because of a shortage of appropriate placement settings, social workers often cannot place children in homes that are able to meet their psychological needs. Therapeutic foster homes represent one treatment approach designed to meet the mental health needs of children in the child welfare system. Under the best of circumstances, therapeutic foster care programs can carefully select foster families with the requisite skills and abilities to care for children who run the gamut from those who are severely emotionally disturbed to those with extreme behavioral and conduct disorders. Placing children in a therapeutic foster home situation often alleviates the need for placement in a more restrictive and expensive hospital or residential treatment setting.[47] Since the majority of children in foster care suffer from moderate to severe mental disabilities, it might be argued that most foster home programs should attempt to develop an appropriate psychologically therapeutic milieu to support the mental health needs of these children.[48]

Children in the juvenile justice system represent another group of children with a high rate of mental health problems. It is difficult for these children to receive the services they need. Like the foster care system, the juvenile justice system is structured with incentives that often preclude adequate attention to the mental health needs of their clients. Although several models of coordinated mental health and juvenile justice interventions exist, the extent to which these programs are used and their efficacy within the state of California is not known.

Child Mental Health Policy

Children's mental health has been the subject of both professional and public policy concern for most of the century. Beginning in 1909, the first White House Conference on Children recommended that the federal government develop new programs to care for emotionally disturbed children. The 1930 White House Conference on Children concluded that emotionally disturbed children have the right to develop like other children and once again recommended the development of new programs for their care. Subsequent commissions and expert panels have expanded this basic recommendation in scope and specificity.

Various select panels and investigatory reports have made strikingly similar observations and recommendations:

- Many children are underserved.
- Disadvantaged minority children and adolescents are even more underserved.
- Parents and families of mentally ill children are unsupported and unserved.
- Services are confused, fragmented, and lack the coordinated planning necessary to serve the child and family's best interest.
- Medicaid and public mental health monies do not provide children access to comprehensive high-quality services.

- Services are heavily weighted toward expensive inpatient hospitalization and are not balanced with improved residential, outpatient, and preventive services.
- Mental health services, including developmental assessments, should be part of general health care.

Unfortunately, while the recommendations of many of the commissions are the same, political action has been lacking.[49] For our specific California policy recommendations, see Appendix 9-2.

Nevertheless, California has been considered a leader in the area of mental health policy and service delivery over the past twenty-five years. In 1969, California enacted the Lanterman-Petris-Short Act, which changed the California state hospital commitment system, placing greater responsibility for state hospital admissions on county mental health programs.[50] Subsequently, many states followed suit. The 1970s witnessed the passage of revised, smaller legislative packages aimed at dealing with the results of the Lanterman-Petris-Short Act.

In October 1983, an Assembly Select Committee on Mental Health was appointed to review all mental health law and practices within the public mental health system in California. This Select Committee organized broad, insightful, and in-depth hearings on mental health law and practice. As a result of the committee's deliberations, numerous bills were introduced addressing the service needs of children and youth. This legislation included the development of better after-care case management plans for children being released from state hospitals, better regulations governing community treatment facilities and residential treatment centers for children, and additional funding to expand mental health programs for people under age 18. In addition, a special project was initiated in Ventura County to address the fragmentation and lack of coordination as well as the paucity of preventive services. The Ventura Project demonstrated the effectiveness of a comprehensive coordinated child mental health service system built on existing service capabilities. Furthermore, other laws mandated that by January 1987, each county initiate a plan for the development of coordinated systems services to address the needs of seriously emotionally disturbed children.

In 1984 and 1985, legislation was passed that mandated the Department of Mental Health to assume responsibility for providing all related services, including mental health services, for handicapped children and youth. Under this act, services are to be provided at no cost to the parent or child.

In 1987, Assembly Bill 377 was passed without funding. The bill established a comprehensive mental health system for seriously emotionally disturbed children and adolescents in counties that choose to participate. This legislation was modeled on the current Ventura pilot project (funded by the Department of Mental Health) and is designed to coordinate a system of mental health programs for public agencies serving children. Programs include, but are not limited to, special education, foster child services, protective services, and juvenile justice services.

Financing Mental Health Services

Mental health services devoted to the needs of children are provided through a patchwork of federal, state, and private program funding. Federal programs include the following:

- Alcohol, Drug Abuse, and Mental Health (ADM) block grants to states for community mental health centers in which 10 percent is set aside for children's programs
- Federal health insurance programs (for example, Medicaid and, to a lesser extent, Medicare and CHAMPUS) providing financing for mental health services delivered in both the mental health and medical systems
- The Education for All Handicapped Children Act (Public Law 94-142), which provides for early diagnostic, informational, and related psychological services

- Title XX funds used for assessment, treatment, and support of children and families at risk of child maltreatment and neglect
- The Adoption Assistance and Child Welfare Act (Public Law 96-276) which funds special child welfare services to children and families in crisis
- Child and Adolescent Service System Programs of the National Institute of Mental Health (NIMH), intended to coordinate mental health and other services for severely mentally disturbed children
- Title 5 Maternal and Child Health block grant funds for basic health and developmental services for low-income mothers and at-risk infants.

In addition, a variety of federal programs directly or indirectly address the mental health needs of children. Examples include:

- Child Abuse Prevention and Treatment Act Programs
- Victims of Crime Act Programs
- Foster Grandparents Program
- Adolescent Family Life Program
- Aid to Families with Dependent Children Program
- Supplemental Security Income.

All these general federal programs are specifically implemented through California statutes. Most mental health service resources provided in the mental health system are financed primarily through the state Department of Mental Health.

Determining the exact amount of expenditure for children's mental health services is difficult for several reasons:

- Block grant and state funds for children's mental health services are combined with resources for adults and for alcohol and drug abuse programs.
- Medicaid/Medi-Cal expenditures for mental health services can only be determined for expenditures to mental hospitals and other specific mental health providers, and do not take into account mental health services provided by pediatricians, family practitioners, and others.

Medicaid is the state insurance program that has the greatest potential to meet the mental health service needs of low-income children. California's Medi-Cal system provides funds for mental health services provided by physicians and psychologists, including diagnostic and treatment services. Medi-Cal has restrictions, however, on the types of service reimbursed and the frequency of allowable services. Short-Doyle Medi-Cal provides funds for some additional services. Unfortunately, neither Medi-Cal nor the Short-Doyle Medi-Cal programs was designed to deal with the wide range of mental health problems afflicting children. For this reason, coverage for essential diagnostic, treatment, and rehabilitative services is spotty at best. For certain age groups of children, foster children, and children in the juvenile justice system, these fundings programs are even more inadequate.

Medi-Cal's CHDP program provides funds to reimburse physician screening, diagnosis, and treatment of children under 21 years of age. Federal and state guidelines require the inclusion of a developmental assessment as part of the service package. Such a developmental assessment can reveal emotional, cognitive, or behavioral difficulties. At present, problems have arisen both in physician compliance and in assessment thoroughness. Nonetheless, CHDP still represents an ideal program for early identification and referral for young children. Modifications in federal guidelines allow states to develop targeted Early Periodic Screening Diagnosis and Treatment Program (EPSDT)/CHDP services—with augmented services and augmented periodicity—thus allowing states to enhance and target special services for children at greater risk.

Another important recent modification in federal law, the Consolidated Omnibus Reconciliation Act of 1985 (Public Law 99-272), allows Medicaid to cover the cost of case management services. Under the provisions of this law, case management is defined as those services that assist individuals eligible for Medicaid to gain access to needed medical, social, educational and other services. Although California has not taken advantage of these potential funds, such funds would provide needed services to help children and families negotiate the tangled maze of services and service providers. This kind of reimbursement is especially important for providers with a high volume of complicated, under-reimbursed Medi-Cal patients.

Chapter 10

Child Abuse and Child Welfare Services

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Children deserve the opportunity to grow up in a safe, permanent, family living situation. Child abuse and neglect interfere with this opportunity and demand effective preventive and interventive services. This chapter reviews the conditions of children who are physically abused, sexually abused, emotionally maltreated, and neglected, and provides a profile of those who are identified and served by child welfare services. Since reducing deaths from child abuse is the minimum goal of child welfare services, child abuse-related deaths in California are reviewed. This review is followed by consideration of the number and type of children served by the four major child welfare programs and the apparent overall condition of children in the child welfare system. The chapter describes the number of children receiving services, with the caveat that these statistics may better reflect service availability than service needs. Gaps in currently available data and services are indicated, with the goal of improving information systems and programs for the care of California's most vulnerable children.

Child abuse usually demonstrates that a family and a community are failing a child in multiple ways. Child abuse and neglect occur when the child, parent(s), and community lack adequate ameliorative or protective resources. Child abuse follows from a constellation of family problems and service shortcomings. Although child abuse occurs in families of all sorts, a disproportionate amount of abuse arises in hazardous home environments. Such environments may be characterized by substance abuse, spousal assault, inadequate housing, residential transience, unemployment, overburdened parent(s), and poverty. Child abuse further endangers the futures of children living in such families. The minimum acceptable condition of children is to be free from child abuse.

Abused and neglected children, if unassisted by children's services, are at great risk of present and future hardship. Although the specific consequences of serious physical abuse, sexual abuse, and neglect vary, each can block children's efforts to achieve physical, social, and educational success. Abused children in California have significantly higher rates of health and mental health problems than the general population.[1] They also suffer more than their share of such undiagnosed problems as hearing and vision loss, behavior disorder, and sexually transmitted disease. Physically, and often sexually, abused children are more prone to be assaultive and antisocial.[2] Abused children are often so distracted from their education by fear, confusion, hunger, and ill health that they cannot meet their educational challenges and are overrepresented in special education programs and among dropouts.[3]

Children who are physically abused, sexually abused, neglected, and/or emotionally abused experience degradation, confusion, isolation, and physical and psychological suffering. As portrayed in the following vignettes, many children suffer from more than one kind of abuse.

Bobby is 6 years old and in the medical emergency room because of large lacerations on his right arm and leg—he had been severely bitten by his family's Doberman pinschers. A medical examination revealed previous broken arms (both) and current facial bruises. The bruises (and possibly the earlier breaks) resulted from punishment by the father when Bobby screamed because of being bitten by the dogs. Investigation of the home found seven dogs, an utterly befouled house, little food for the four children, and no sleeping quarters for the children that were off limits to the animals. Bobby is clearly a victim of physical and emotional abuse as well as of neglect.

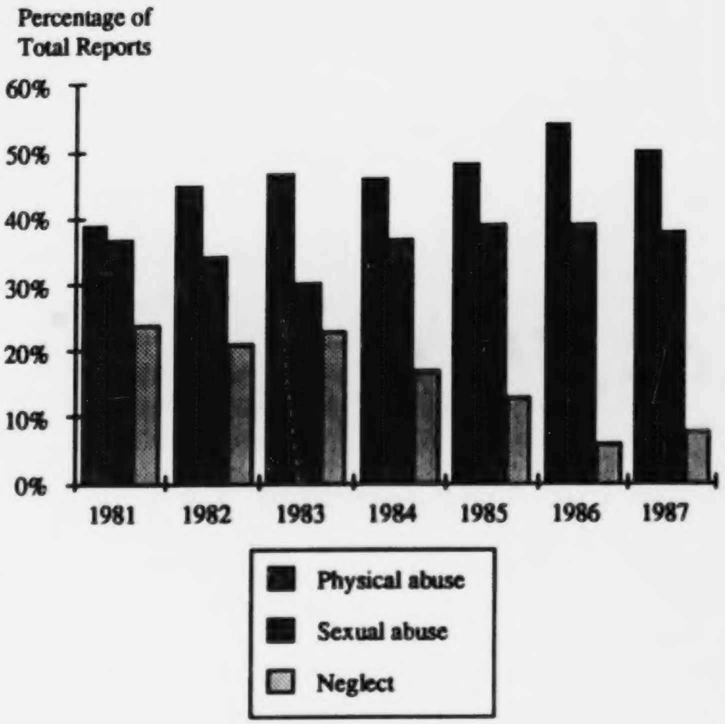
Mindy is 4 years old and the middle sister of three. Her grandmother flagged down a police car in her neighborhood and asked the officer to take Mindy and her sisters (ages 7 and 3) to the police station, saying that neither she nor her daughter was capable of caring for them. The children's mother was involved in drugs and *illicit activities; the children were poorly fed, ill-supervised, and were often seen near or in the street. Mindy and her little sister are not toilet trained (but they rarely have diapers to wear) and barely talk. Since their mother's substance abuse problems were worsening and a violent man had moved into the house with the children, Mindy's grandmother was afraid for the lives of Mindy and her sisters. Depending on the county in which she lives, Mindy may or may not receive services as a severely neglected child.*

Ana's mother drinks heavily and seems to change boyfriends every few months. Ana stays in her room after school and does not go near these men, who often fondle her. Ana's father is the worst of all. He no longer lives with Ana and her mother, but stops by to see Ana and party with her mother. He also touches Ana's genitals after he is drunk, when her mother is asleep or unaware. This has gone on since before he moved out. Recently, he has begun to put his penis inside of her. She told the school nurse of the pain and that she wants it to stop. The nurse called her county's child abuse telephone number to report this sexual abuse and begin the child protection process.

Physical Abuse

Physical abuse involves the nonaccidental infliction of serious physical harm to a child and accounts for a growing proportion of all investigated reports. From 1981, the proportion grew 30 percent and the numbers of investigated physical abuse cases increased from about 7,500 to more than 30,000 per year (see Figure 10-1). Some of this increase may reflect a change in identification practices that emphasize physical abuse rather than neglect—even though many children are both abused and neglected. The increase in physical abuse probably does not simply reflect changes in reporting but instead indicates that children increasingly bear the brunt of physical attacks triggered by deepening poverty and its aggravating elements.

FIGURE 10-1 Child Abuse and Neglect Reports Received in California, 1981–1987



SOURCE: State of California, Department of Justice.

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Sexual Abuse

Sexual abuse occurs when a child has been sexually assaulted (as defined in the penal code) or is at substantial risk of such assaults because the parent fails to protect the child. The proportion of all abuse cases involving sexual abuse has increased only 3 percent since 1980, but the number of reported sexual abuse cases has more than tripled. The increase in percentage and rate is even sharper since 1974. Sexual abuse reports represented 15 percent of all reports in 1974, and rose to 39 percent in 1987. During the same time period, the number of sexual abuse reports increased from 607 to 22,416, a thirty-seven-fold increase. This increase mirrors a national concern with child sexual abuse and is partly a function of the passage of legislation in California in 1975 to establish a training and demonstration center for the prevention of sexual abuse. Before that time, the reporting rates per county were less than 0.1 percent of children; they rose to 1.4 percent in 1980. Counties that developed coordinated sexual abuse prevention and service centers had significantly sharper increases in reports than those that did not and sharply cut the discrepancy between the incidence and reporting rates for sexual abuse.[4]

Neglect

Child neglect occurs when a minor has suffered, or is at substantial risk of suffering, serious harm or illness as a result of lack of care, supervision, or protection by a parent or guardian. The precipitous decline in child neglect reports corroborates reports from service providers that they are insufficiently assisting families that neglect their children. The change in reporting of general neglect makes it unclear whether rates of severe neglect have changed. (General neglect includes marginal living conditions or homelessness, poor nutrition, and poor parenting, but does not include life-threatening conditions; severe neglect involves acute threats to the well-being of the child.) The ratio of general neglect to severe neglect cases is roughly forty to one in California's most populous counties. More than 110,000 children received assessments, services, or both in 1986 because of general neglect. Agencies currently have discretion to serve general neglect cases. In Los Angeles County, placement of neglected children in out-of-home care increased by 33 percent from 1984 to 1987. These placements include many general neglect cases, but are also increasing because of a 453 percent increase in referrals of drug-exposed infants.[5] The apparent statewide decrease in reports of severe neglect (which includes life-threatening deprivation of necessities, dangerous conditions in the home, or both) may be an actual decrease resulting from more timely reporting and investigation.

The decline in investigated and confirmed reports of severe neglect do not, however, seem to have resulted from any service initiatives begun in 1986 or shortly before. Instead, they seem to reflect a steady shift in priorities away from reporting and serving neglectful families. This process was accelerated by sharp increases in other kinds of abuse (especially sexual abuse) and limited funding to accommodate these additional cases.

County resources (such as homemaker assistance) for serving general neglect cases are quite limited and often are not used without compelling evidence of a case's potential severity. With the passage of Senate Bill 243, county social service agencies have fewer options for serving these children. This is considered desirable by some who are particularly concerned that the child welfare system has overreached its mandate and that neglectful families are primarily poor, underserved, and in need of a better network of voluntary community services.[6] At this time, however, no service system for generally neglected children (like Mindy) exists. Neglectful families (general or severe) are among the most difficult to help when their children remain at home. Even with services, neglected children who remain at home are at a considerable disadvantage when compared to children who receive out-of-home care (at least for a time) because their families are unlikely to provide the corrective care the children need.[7]

Reporting and Investigation

Child abuse report rates, which include reports of physical, sexual, and emotional abuse as well as neglect, have increased by 212 percent over the last seven years in California (Table 10-1). Since 1980, reports of physical abuse judged serious enough to warrant investigation (and proven not to be unfounded) have increased fourfold. Sexual abuse reports more than tripled. Since 1982, emotional maltreatment rates have increased 4.6 times.

TABLE 10-1 Child Abuse Investigation Reports Received[a]

Year	Total Reports	Rate per 1,000 Children	Percent Increase
1980	19,572	3.05	
1981	25,550	3.91	28%
1982	32,650	4.90	25
1983	43,985	6.47	32
1984	45,515	6.58	2
1985	60,627	8.52	29
1986	56,811	7.98	–6
1987	61,090	8.31	8

Type of Abuse	1981	1982[b]	1983	1984	1985	1986	1987
Physical	38.5%	45.5%	47.4%	46.9%	48.4%	52.3%	50.3%
Sexual	35.7	34.8	30.0	36.5	39.0	38.8	36.6
Severe neglect	22.3	21.2	21.6	18.1	14.4	5.1	5.5
Emotional	n.a.	3.5	4.6	3.6	4.3	4.2	5.1
Other[c]	3.5	6.1	5.4	3.5	3.0	3.3	1.3

[a] California Department of Justice reports of child abuse include investigated cases. These are cases considered to be the most serious. These figures are far lower than those derived from counting all the child abuse reports made to the Department of Social Services.

[b] Beginning in 1982, some cases involved multiple types of abuse, and multiple responses were recorded, resulting in totals of more than 100 percent.

[c] Includes other abusive behaviors, abandonment, and child deaths.

SOURCE: Data provided by State of California, Department of Justice (1980–1986).

There are also a few statistics on the other side. For example, since 1980, reports of serious neglect decreased by one-fourth. Also, rates of investigated and unfounded child abuse cases have recently stopped increasing in California, although national child abuse rates have grown at a mean annual rate of 13 percent since 1980. It would be wrong to conclude that child abuse and neglect has leveled off in California, however, because the drop is well accounted for by administrative changes in reporting. Reports of severe neglect have excluded all cases of general neglect since 1985, and severe neglect reports dropped by two-thirds between 1985 and 1986. If the severe neglect rate had remained at the average level of the five prior years (7,804 cases per year), the overall child abuse rate would again have risen in 1986 and 1987 by an average of 7.7 percent per year. This increase is still lower than the 17.4 percent yearly increase of previous years and indicates that the rate of increases in investigated reports in California is slowing. Almost 1 percent of California's children are the subject of an investigation for child abuse each year.

Comparing child abuse rates in California and other states is difficult at best, because reporting methods vary widely across states. According to the American Humane Association, California ranked fifth, sixth, seventh, and tenth nationally in child abuse reports from 1982 to 1985 (Appendix Table 10-1).[8]

By report of the National Committee for the Prevention of Child Abuse, California's child abuse and neglect reporting rates increased 7 percent in 1983, 18 percent in 1984, and 20 percent in 1985. These increases rank California twenty-third, eleventh, and second nationally in terms of reporting rates, showing either that Californians have responded with extraordinary concern to confront child abuse, or have not kept pace with other states in preventing child abuse. Given the state's long-standing commitment to increased child abuse reporting, the first interpretation is more compelling. (As previously discussed, this increase in reports has leveled off since the end of fiscal year 1985.) State-by-state increases in rates (and national ranks) are shown in Appendix Table 10-2.

Many reports of child abuse are investigated but judged not serious enough to be substantiated. (These are included in the 61,090 reports in 1987.) However, that a report is unsubstantiated does not mean abuse did not occur. In a recent study involving three California counties, only 28 percent of reports were substantiated, yet 53 percent of all cases involved some incident of maltreatment.[9] Abuse is often not substantiated because it is judged not severe enough to warrant spending scarce resources. The estimated 28 percent unsubstantiated rate places California well below the national average of 43 percent.[10] Although the 25 percent of reports that involved abuse but were unsubstantiated were judged to be less severe than those that received services, services were not provided primarily because they were not available. In *Final Report : Private Individuals' Reports of Child Abuse and Neglect*, J. M. Giovannoni concludes that "these unsubstantiated cases may not represent so much a failure of reporters to make proper reports, but rather they are a reflection of gaps in the total array of community services for children and families."[11]

Many children and families who need services other than child welfare services are becoming involved in the child welfare system. For example, children who are the center of highly acrimonious divorce battles are unusually likely to be investigated for later unfounded reports of child abuse. Reports of child abuse that are anonymous or made by nonprofessionals are also likely to be unfounded. Children and parents who are the subject or source of unfounded child abuse reports often need voluntary community-based family services other than those now provided in the child welfare system.

Child Abuse Deaths

Child welfare services have a broad mission to protect the futures of children. Whereas there is disagreement about the proper breadth of this mission, minimizing deaths that result from abuse and neglect is considered the hallmark of an effective child welfare system. Nationally, the number of child abuse deaths rose by 29 percent between 1985 and 1986 in contrast to a 2 percent decline the previous year.[12] Almost two-thirds of children killed by parents are 1 year old or younger.

State-by-state comparisons exclude California because California lacks a central repository for child abuse fatality reports. California Department of Justice figures on child abuse deaths are a poor indicator of actual deaths because they reflect only cases that were initially reported as deaths and exclude cases that were initially reported as child abuse and in which a subsequent death occurred. Deaths of children at the hands of their parents in California as counted in this manner have increased 6 percent per year (from fifty-six in 1982 to eighty-three in 1987).

These are certainly only a small portion of the deaths actually due to child abuse; there is no doubt that other child abuse deaths are mistakenly reported as accidents or occurrences of Sudden Infant Death Syndrome (SIDS). One epidemiological investigation suggests that the actual rate of child abuse deaths may be more than four times higher than the reported rate even in states with adequate reporting systems.[13] A task force in Los Angeles identified 48 deaths rather than the 9 reported in Los Angeles County during 1984. Between 1985 and 1986, the number of "suspicious deaths" that may have been caused by child abuse nearly doubled (from 103 to 203).[14] Alameda County had six child abuse deaths in the first half of 1987, but before the county's double-check, none were reported by homicide investigators and hence none would have been counted. A recent review of deaths of children in foster and emergency shelter care in San Francisco from 1984 to 1986 found that 6 deaths were suspicious. Department of Justice data for those years identify just one death in that county due to child abuse in any setting. More complete figures on the deaths of children in foster care and emergency shelter care are available from a few counties and indicate that 24 children died in these counties in those two years.[15] Given that these counties represent about 25 percent of all of California's population, the statewide yearly rate of children who die while in care can be projected at 48. Other data say that no more than 50 percent (and possibly 25 percent) of children who die from child abuse are known to child welfare services. A small percent of them would be in out-of-home care. All child abuse deaths probably total closer to four times the rate of deaths among children in out-of-home care, or 192 in those two years. This improved but inexact estimate is still inadequate to answer a question about the effects of preventive and interventive child abuse services in California — that is, did we save lives?

Better collection of child abuse and child death data is crucial to improving the condition of children in California. Reports of both general and serious neglect should be counted by the Department of Justice to help determine whether general neglect is growing or declining. Information is especially important as we move toward a service delivery system that excludes general neglect from the auspices of court-ordered child welfare services. Unsubstantiated cases should be divided between (1) those that do or do not include abuse and (2) those that do or do not receive services. In this way, the numbers of children who are maltreated and receive no intervention can be better tracked. Determining repeat abuse rates for families currently or previously receiving child welfare services is crucial. This determination will require a statewide case-by-case child welfare information system, a project both achievable and advisable.

Each year, California should collect data from every county on the number of deaths from child abuse that occur before, during, and after participation in the child welfare system. Reports of child abuse deaths are supposed to be sent to the Department of Justice by police homicide investigators. However, they are often not sent in because homicide investigators are not familiar with child abuse reporting and are not committed to the importance of collecting such data.

Two further recommendations on the reporting of deaths should also be made. First, coroners should be funded to use computer information systems to keep track of families with child deaths — whether such deaths are reported as SIDS, perinatal death, or accidents. In this way, investigators might be able to avoid such cases as recently occurred in California in which a mother's eight children all died before the age of 3. Charges of child abuse of the eighth child were, tragically, too late. Second, the state should define a "suspicious death" category, in which deaths that could not be proven to be child abuse but were investigated as such are recorded. This category will create a second data source for estimating whether child abuse deaths are decreasing.

Child abuse and child death data are imprecise and difficult to interpret. Yet even the most pessimistic observer of child abuse prevention and treatment services must admit that increases in physical and sexual abuse reports may reflect a more efficient reporting mechanism and a growing sensitivity to children's needs. At the same time, the most sanguine optimist cannot be confident that the leveling-off of rate increases is a good sign; it may indicate widespread complacency and diminished concern for less dramatically maltreated children who still need services. It is uncertain whether the slowing increases in reporting rates of child abuse represents (1) less reporting of suspected child abuse, (2) tighter practical definitions of child abuse, (3) fewer available investigative services, or (4) a leveling-off of the increases in severe child abuse and neglect. The last three reasons probably contribute most to the decline in the child abuse rate.

There is reason for both hope and concern regarding abused children. In view of the unprecedented and escalating numbers of reports that continue to be filed, the public does not seem jaded about reporting child abuse. Also, for the last decade California has been in the forefront of a campaign encouraging public awareness of the importance of reporting child abuse. The state's Office of Child Abuse Prevention has funded community-based services and research for more than a decade. It seems evident that Californians now report a substantially higher proportion of abuse than ever before.[18] This is not to argue that underreporting no longer exists, but rather to indicate that the rate of underreporting is probably steady. Physical and sexual abuse comprise the majority of child abuse reports, and these cases continue to receive top priority in child welfare services. Given this priority and the increase in social workers investigating these reports during recent years, it is probable that these numbers represent a true leveling-off in the rate of physical and sexual abuse.

Investigations based on reports of general and severe child neglect have also been curtailed. Although one can speculate that the most severe forms of neglect are diminishing, current child abuse reporting systems do not document the specific harms experienced by children. For example, there is not at this time any systematic way of monitoring whether the proportion of sexual abuse reports that involve fondling or penetration are changing. Nor are there accurate tallies of the increase in cases involving drug-exposed infants and drug-addicted parents. Across time and place, service providers tend to report that these drug cases are getting worse. That is likely to be true given the growth of homelessness, drug abuse, and extreme poverty in California, but it is not now verifiable. A system of key indicators of specific harms suffered by children and of crucial conditions of family life is essential to making informed policy and practice decisions. In all, however, California seems to have moved forward dramatically in closing the gap between the events and reports of abuse. This is a promising starting point for the delivery of child welfare services.

Child Welfare Services

The premise of the California child welfare system is that, unless absolutely necessary, services should support—not supplant—family life. Services are intended to protect the child at home and, if the child requires temporary removal, to provide intensive efforts to return the child home. A fundamental assumption of these services is that children's birth homes (even if they have been the site of child abuse or neglect) can be rehabilitated. Such a rehabilitated home is considered superior to a foster home, which, while it may often be safer and possess more growth-promoting resources, is temporary and lacks other intangible benefits. If the child is unable to return home, then adoption by the foster parents, relatives, or another family is the next best option.

In 1982, Senate Bill 14 restructured California's mandated Child Welfare Services into four discrete programs: Emergency Response, Family Maintenance, Family Reunification, and Permanent Placement. Discussion follows on the first two of these programs; the second two are discussed in the later section on foster care. The four major goals of the legislation are (1) to prevent unnecessary placement of abused and neglected children into foster care homes, (2) to reunite as many foster care children with their birth parents as possible, (3) to reduce the number of children in long-term foster care by placing them in adoptive homes, and (4) to ensure stable and family-like placements for those children who remain in foster care.

The Emergency Response Program

The state's Emergency Response Program is designed to provide early intervention for families in crisis, and reasonable, prompt protection of children. Every county is mandated to provide immediate in-person response, twenty-four hours a day, seven days a week, to reports of abuse, neglect, or exploitation. The response should include initial intake services and crisis intervention. The goal should be to maintain the child at home or to protect the child's safety through placement in Emergency Shelter Care. Shelter care may be provided in a foster family home, a larger centralized facility, or both.

Citizens made almost 375,000 contacts with Emergency Response Unit staff in 1987, or approximately one inquiry about whether to report child abuse or neglect for every twenty children in the state (Appendix Table 10-3). This represents a 236-percent increase since 1985. These numbers are far higher than those provided earlier in the section on child abuse statistics because many of these contacts did not require full investigations and were quickly closed. It is not known how many of these contacts involved repeat cases. Rates of inquiries varied across counties, from a low of two per hundred children in Marin County to a high of fourteen per hundred children in Del Norte County. Whereas these variations may reflect differences in the conditions of children in these counties, they are also a function of reporting and practice differences between counties. As previously noted, such statistics may tell less about the conditions of children than about the conditions of children's services.

The majority of Emergency Response Unit inquiries (74 percent) were resolved with no further services. They often involve clarification of what abuse entails and referral to other community services. Of the remaining 26 percent of abuse reports, 21 percent were referred to other child welfare services. Among those, the majority (59 percent) were referred to the Family Maintenance Unit, in which families receive services while the child remains at home. About 20 percent of children who received services were placed directly in foster care with the intention that they would later return home. Fewer than one out of every hundred children accepted into child welfare services was first placed in the permanency planning unit without that intention.

Rates of services provided to different classes of Emergency Response cases varied substantially across counties (Appendix Table 10-4). For example, Del Norte County ranked highest in services to children suffering general neglect, and second in physical abuse and sexual abuse. Yuba County ranked highest in cases of physical and sexual abuse, and second in general neglect. Although statistical comparisons can be made, these rankings do not reflect the absolute severity of the problems in respective counties, because the local standards of care and availability of services are as strong a determinant of service provision as is need.

Of the Emergency Response services provided in California in 1986 (Appendix Table 10-5), one-third were for general neglect, and almost as many were for physical abuse. Almost one-fifth of services were for sexual abuse. Abandonment by and incapacity of parents accounted for another 9 percent of services, and emotional abuse for 3 percent. Proportions of reasons for services were roughly comparable across counties.

TABLE 10-2 Length of Time from Referral to Response to Closing of Case or Commencement of Services, 1985

	Number of days	Children	Percent
Referral to Response Time			
	0–1	11,343	47.1%
	2–3	4,114	17.1
	4–5	2,307	9.6
	6–7	1,846	7.7
	8+	4,460	18.5
	Average: 4.2		
Referral to Closing of Case or Commencement of Services			
	0–5	5,998	24.9%
	6–10	5,345	22.3
	11–20	4,653	19.3
	21–30	3,307	13.7
	31+	4,768	19.8
	Average: 21.4		

SOURCE: California Department of Social Services, *Preplacement Preventive Services: Emergency Response and Family Maintenance Programs*, 1986.

In a random sample of the Emergency Response caseload in April 1985, the Statistical Services Branch of the state of California found that the average number of days from referral to agency response in an Emergency Response call was a little over four days, with 47 percent of calls responded to in one day or less (Table 10-2).[17] However, almost one-fifth of calls were answered after one week had passed. Children who were physically or sexually abused received the speediest service. Neglected children waited the longest for evaluations. The average number of days between (1) referral to the Emergency Response Unit and the (2) closing of the case or the commencement of services was twenty-one days.

The same sample compared the ethnicity of children receiving either Emergency Response or Family Maintenance services (Table 10-3). The ethnicity of children was fairly comparable between the two services, with whites comprising about half of those receiving services, followed by Hispanics and blacks. Black children, who comprised only 9 percent of all of California's children at that time, received a disproportionate share of Emergency Response and, especially, Family Maintenance services.

TABLE 10-3 Characteristics of Children Receiving Services: Emergency Response versus Family Maintenance*

Ethnicity	Emergency Response	Family Maintenance
White	55.0%	42.5%
Hispanic	24.6	28.8
Black	12.0	19.6
Asian	1.6	2.9
American Indian	0.8	0.3
Filipino	0.2	0.9
Other	5.8	5.0

* Random sample of 1,203 cases closed in April 1985.

SOURCE: California Department of Social Services, *Preplacement Preventive Services: Emergency Response and Family Maintenance Programs*, 1986.

Black children are reported for abuse and receive formal services at twice the rate expected from simple population data. (This may partly be because black children receive other public income maintenance at a similar rate.) All in all, recipients of child welfare services are disproportionately from minority groups in California—as they are nationally. More than half of the families whose children are under court-ordered protection at home are minority families. This high percentage appears largely attributable to higher rates of poverty.

The majority of families in the Emergency Response and Family Maintenance caseloads received initial intake, counseling, and crisis intervention services; many also received parent training. More concrete services to prevent family breakup—such as emergency shelter care, transportation, homemaking education, temporary in-home care of children, and out-of-home respite care—were received by only about 3 percent of families in the Family Maintenance Program even though these are known to help preserve families.[18]

Emergency Shelter Care. Emergency shelter care services are under the auspices of the Emergency Response Program and are provided for children who are removed from their homes because an investigation finds they have been abused or neglected. The basic purpose of shelter care is to provide food, shelter, and protection for these children temporarily, until a more permanent disposition can be achieved. Shelter care has an intended limit of thirty days unless special administrative exceptions are made. Currently, however, the statewide average length of stay is about forty days. This is inconsistent with the program's design as a short-term facility and is hard on children, who generally prefer more predictable and permanent situations. When plans for permanent situations fail, children may also return to shelter care; some shelters report that more than 40 percent of their children are admitted directly from mental health facilities that are unable to care for them.[19]

California shelters are experiencing increased admissions of infants and younger children. In 1985, counties reported that more than 30 percent of the children in shelter care were younger than age 3. By 1987, this proportion had increased by another 10 percent.[20] Los Angeles County showed an increase in the number of infants in care from an average of just over 100 in 1984, to 287 in 1987—the majority were diagnosed as showing "failure to thrive" or had drug-dependent mothers. Subsequently, the number of infants placed in hospitals and group care rather than with families has increased sharply.

Shelter care has the potential to be a gateway to better services for children in and out of the child welfare system. That is, children who are subsequently returned home—whether or not they are made dependents of the court—could return home with the benefit of additional information on the educational, psychological, and health services available to them. There are no state guidelines or procedures for the care, referral, and follow-up of children who enter the system. Yet counties report that between 10 and 50 percent of their children suffer from cerebral palsy, fetal alcohol syndrome, drug addiction, and neurological disorders—all serious medical conditions requiring sustained care and treatment. At least one referral to a therapeutic resource could be provided to children on leaving shelter care. Referrals to community agencies could follow, but few California counties even provide a Child Health and Disabilities Prevention (CHDP) exam for children in foster care or systematic referral to treatment resources.

Children who are removed from their homes and children who are returned home from foster group situations are in crisis. Too often they stay in shelter care for a lengthy period, do not receive a full assessment, and are not guided to needed services. Also, more medically and behaviorally troubled children are in shelter care than ever before. As a result, several counties have moved toward larger, more centralized shelter facilities that promise more specialized services for children with severe physical and mental health problems. However, unfortunate problems often arise in larger facilities. Evidence from a recent review of county shelter care programs suggests that children run away from larger facilities more often.[21] Alternative ways to provide more coordinated services are worth pursuing. For example, decentralized services with adequate links to treatment resources may better maintain the ability of parents and social workers to visit the child and help maintain continuity of educational and health services after the child leaves the shelter. This approach might involve trying co-located teams of medical and mental health personnel to provide better assessment and case management for children in shelter facilities.

Children's experience with shelter care is difficult to describe due to the absence of mandatory and uniform recordkeeping procedures. The inability to identify a child each time he or she enters shelter care precludes the establishment of accurate recidivism rates. Such recordkeeping would be facilitated by a statewide child welfare management system with a unique designator for each child. The application of standard definitions for the length of time a child must be absent from the shelter to count as a runaway would clarify the seriousness of the runaway problem.

Children in out-of-home care are ill served by the tenuous relationships between regular education and special education and between shelter care and foster care. Some shelters have only two hours of educational services available to students each day.[22] Such inadequacies are unforgivable. Programs like the Foster Youth Services Program—which provides tutoring, counseling, and job development for foster youth—help provide linkages between schools and foster children.[23] A recent evaluation has found this program to be successful; however, its funds have been frozen, and only four such state-funded programs now exist in California. Given the findings that 30 to 50 percent of children in shelter care need special education[24] and that educational handicaps are among the greatest difficulties faced by emancipating adolescents,[25] more attention should be paid to examples such as the Foster Youth Services Program.

Homelessness and General Neglect. Many of California's children are among the estimated one to two million Americans living without the basic necessities of home and with constant exposure to the street's hardships. The lack of a home can create special problems for children in terms of their need for schooling, health care, and mental health services. In one investigation of homeless children, about 50 percent showed developmental lags, anxiety, depression, and learning difficulties, and needed further mental health evaluation.[26] Another study found homeless children were infested with head lice at thirty-five times the national rate, suffered serious skin ailments four times as often, and had serious dental problems ten times as often.[27]

National and state figures on the number of homeless children vary widely, as most reports are from irregular samples of people using homeless shelters in particular cities. Shelter operators in Los Angeles, Alameda, and Orange Counties recently reported that more than half of those seeking shelter are families with children.[28] The number of families with children requesting emergency shelter increased 30 percent in Los Angeles between 1985 and 1986. Until the public housing stock is renewed, children in California will continue to have their lives jeopardized by homelessness.

The responsibility of child welfare services for homeless children is an issue moving toward some resolution and clarification. The recent *Hansen v. McMahon* decision requires that child welfare services not limit emergency shelter care to children removed from their families, but also provide emergency shelter care to intact homeless families.[29] Subsequent legislation (Assembly Bill 1733) makes money available for nonrecurring special needs and for a month of housing assistance under the state's AFDC program; this allows a homeless family to remain together. This legislation is a strong step in the right direction; it protects families who have not committed abuse or neglect rather than separating children from their families in times of crisis.

Californians generally adhere to the principle that poverty—including homelessness—is not sufficient justification for court-ordered child welfare services. Until the middle 1980s, however, children who lived in cars or on the streets with their parents were considered to be in need of protection and agencies often placed them in foster care. In recent years, as agencies have attempted to focus the use of the child welfare system on families with children at serious risk of injury, drug-exposed children, and children who have been sexually abused, child welfare services have become largely unavailable to homeless or generally neglected children.

Changes in the services available for general neglect cases with housing problems are illustrated by the following case:

Laura (age 5) and her two brothers (ages 2 and 3) were reported to the Child Welfare Service's Emergency Response Unit after they were left in the care of a neighbor's 9-year-old child and their mother did not return. Efforts to identify a family member or neighbor who could care for the three children until their mother returned were not successful, and they were placed in the emergency shelter care facility. The agency had on record three previous reports of abandonment or neglect by the mother. The three children were observed to be very hungry (but not abjectly malnourished), and Laura was suffering from lice and respiratory and skin infections. Laura and one brother appeared to be developmentally disabled. The mother returned home three days later and described her continued difficulty caring for the children and her serious problem with alcohol. She appeared to function in the mildly mentally retarded range. She reported that she knew that Laura should to be on medicine for her infections but did not know the dose or timing for its administration. She could not read the label. The family's apartment had poor heat and was dirty. The refrigerator did not work but did have some juice, bread, and cheese in it. There was no television, radio, or telephone in the home, but there were two chairs, a table, and a bed. This was the third home they had lived in that year, and they were being threatened with eviction. Laura's mother was obtaining AFDC to support her children.

Services to these children and their mother would vary from county to county. In many counties, Laura would receive different services depending on the year she was reported to child welfare services. Prior to the 1982 child welfare reforms (SB 14), these children would most likely have been placed in foster care and very possibly would have remained court dependents into their majority years. The mother's parental rights would not have been legally terminated but she might have lost contact with her children as they and she relocated. In foster care, they would have been more likely to obtain adequate health care and educational support but also to suffer separation from each other and multiple placement moves. On discharge at age 18, they would have had no family to call their own. They might have reunited with their mother if they had maintained contact.

Since SB 14, these children would more likely be returned home and would receive voluntary Family Maintenance services (in those counties with such a program) or court-ordered supervision to help bolster their quality of life. These services are accompanied by priorities for housing, day care, and MediCal. A very few such families would receive intensive in-home services. The family would probably remain together. Whatever the short-term success of these interventions, the family would likely need additional help throughout their growing years and the children would likely need additional educational and mental health services. It is likely, however, that these services would be underused because of their mother's difficulties.

Beginning with the inception of the latest child welfare reforms (SB 243), Laura and her brothers will less likely be required to use formal child welfare services beyond the investigation. Instead, they will more probably receive referrals to other special education, social, and public health services. They will be eligible to wait for public housing, but will receive no priority or special funds— as they would if receiving child welfare services. Only if Laura's mother pursues these referrals, *and* the services are available, can Laura and her brothers receive the aid they need.

The Family Maintenance Program

When abused and neglected children are not considered to be in imminent danger, they remain at home and receive Family Maintenance Program services. These time-limited protective services are designed to prevent or remedy neglect, abuse, or exploitation, as well as prevent separation of children from their families. Families can be ordered by the court to participate in services. Some do so voluntarily. Family maintenance services are limited to six months, but may be extended for two three-month periods when it can be shown that the objectives of the service plan can be achieved within the extended time periods. For court-dependent children, court reviews are conducted at least every six months. Services mandated to be available to all Family Maintenance cases include counseling, emergency shelter care, parent training, out-of-home respite care, teaching and demonstration for homemakers, temporary in-home caretakers, and transportation.

Although the current top priority of federal and state child welfare reform is the maintenance of children at home, Family Maintenance services have not been substantially improved to meet this goal. A review of studies on permanency planning services conducted in California and elsewhere found that services to children in their own homes are often too brief and inadequate to protect them from subsequent abuse.[30] A full 58 percent of the Family Maintenance cases closed in April 1985 received services for fewer than three months (Table 10-4). Recurrence of physical abuse has been reported at percentages as high as 54 percent, 32 percent, and 11 percent in different studies.[31] In one study of families provided with intensive in-home services, 17 percent of families were charged with maltreatment during a five-year follow-up period, compared to 22 percent of families receiving standard services.[32] This practice of brief services not accompanied by solid preventive services fails to protect children.

TABLE 10-4 Family Maintenance: Length of Services

Number of Months	Children	Percentage of Total
< 1	840	15.3%
1–2	2,386	43.3
3	420	7.6
4	258	4.7
5	382	6.9
6	220	4.0
7+	1,002	18.2

Average: 4.1

SOURCE: California Department of Social Services, *Preplacement Preventive Services: Emergency Response and Family Maintenance Programs*, 1986.

During San Mateo County's pilot permanency planning program, 23 percent of the children studied who received services at home were later removed from their homes because of subsequent abuse. Among the children who remained at home, about half suffered continued but not severe abuse or neglect in the subsequent two years.[33] Two children (10 percent) were sexually abused. The researchers concluded:

> Thus the great majority of children left at home were not in ideal situations. Only a very few actually suffered or appeared to be in danger of suffering serious physical injuries through abuse or inadequate care. However, most of the children received only adequate to marginal physical care and many were subject to either active emotional abuse or the lack of parental concern and care.

Recent advances in the technology of intensive in-home services, now under evaluation in a few California counties, suggest some improvements, although longitudinal follow-ups of the outcomes for these children are not available.[34]

The rights of children to remain in the care of their biological parents, and of parents to retain custody and control of their children, are basic to the organization of our society. Services to families in their own homes should be a priority for two reasons: (1) they are probably less costly than long-term out-of-home care, and (2) they are more precisely aimed at society's most troubled families than are child abuse prevention programs. Yet, about three-quarters of emergency response inquiries are closed after the initial investigation, and the average length of time between referral and response is four days. The services most often provided in the Emergency Response Unit are brief crisis intervention and counseling. For those cases that are referred to Family Maintenance Services (15 percent of the total inquiries), the services are often the same. More concrete services—such as parent training, respite care, and homemaker services—would be more appropriate and effective.

California can aim higher than merely to provide minimal supervision of children in high-risk homes. Other states (such as Florida, Tennessee, and Maine) have instituted intensive in-home service programs to prevent the need for placing children in foster care. Although not every family should be preserved intact, from 10 to 40 percent more placements might be prevented if such programs—which are now being piloted in California—prove useful and seem to protect children's developmental potential. Given the lasting difficulties of children served in the child welfare system, short-term placement prevention services delivered by child welfare should be followed by vigilant and resourceful outreach efforts by community-based agencies. Services to assist the many families now deferred from the child welfare system should also be readied to provide ongoing services to children who were abused at home and remained there.

Foster Care

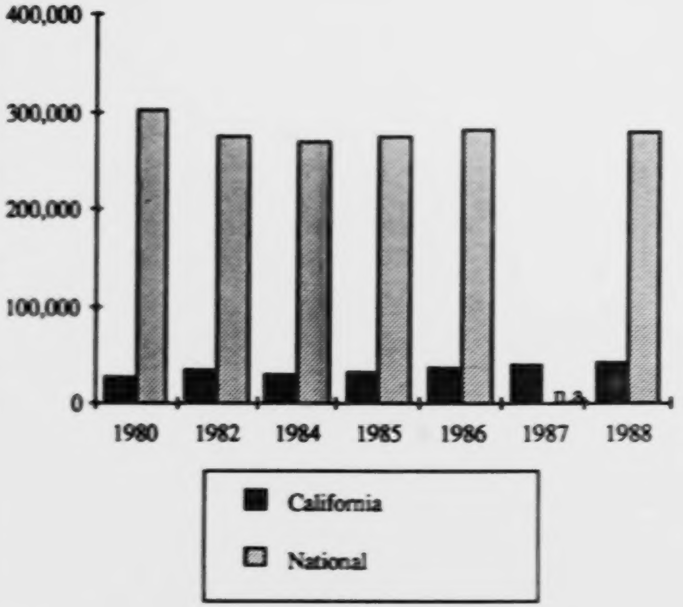
Each year, nearly one out of every hundred California children spends time in foster care. Most will be returned home, but many will remain in foster care until they reach the age of majority. Children enter substitute care because their homes are not safe and relatives are not available to care for them. Although many of them just stay briefly, the average stay is two-and-a-half years. This average time period has decreased since 1980.

The number of children in out-of-home care in California decreased sharply after the enactment of PL 96-272 in 1980 and SB 14 in 1982, while California's proportion of the national total remained fairly steady. Recently, however, foster care use has rebounded in California and has continued to increase (Figure 10-2). Nationally, the number of children in foster care increased by only 6,000 (2.2 percent) between 1984 and 1985; much of that increase is attributable to the increase from California alone.[35] California reported 27,534 children in substitute care in 1980. From 1981 to 1985, the number of children in this type of care increased 12 percent to 31,365, while the national average for states decreased 1 percent.[36] By 1986, the number of children in foster or residential care in California reached 39,387 (a 25 percent increase from the previous year). The nation as a whole had an increase of 6,000 children in foster care between 1985 and 1986;

4,700 of those children were from California. In April 1987 the number had risen to 41,645 (a 6 percent increase).[37] A year later, the number of children in foster care had increased another 6 percent, to 44,337. By January 1989, the number was 50,448.

Many factors contribute to the increases in foster care. Increases in child abuse certainly increase foster care use, but child abuse is probably a less significant factor than other sociodemographic trends: for example, growing numbers of families in poverty and without adequate housing.[38] Nationally, only 14 percent of children who experience substantiated child abuse and neglect end up in foster care.[39] The availability of placement prevention services and community resources in great part determines the proportion of abused children who remain at home. After Los Angeles County instituted its twenty-four-hour emergency command post program, the number of children remaining at home after the initial assessment increased fourfold. About five hundred children per month in Los Angeles are now placed with relatives instead of going into shelter care.[40] (The placement of victims of child sexual abuse is somewhat independent of other factors since strategies for keeping sexually abused children in their own homes are slow in developing.) The ability of related service programs—especially mental health and juvenile justice—to aid out-of-home care programs also influences the foster care rate.

FIGURE 10-2 Yearly Trends in the Number of Children in Foster Care



SOURCE: APWA, *Characterisitics of Children in Substitute Care*, California State Department of Socials Services, 1982.

Most commonly, a child placed in substitute care lives in a foster home. Older children or those needing more intensive care are more often placed in group homes or larger residential care facilities. In the 1986–87 fiscal year, children of all ages were about equally represented in foster care, although the youngest and oldest children were somewhat overrepresented. Children removed because of sexual assault were generally in their teens, while neglect cases tended to be removed at a much younger age. Physical abuse cases were removed equally at all ages.[41] From 1984 to 1987, Los Angeles witnessed a 50 percent increase in placement of children through age 5, whereas children 6 and older showed only a 21 percent increase.

In California in early 1987, the gender and age groupings of children in foster care (Table 10-5) were fairly comparable to national data, leaning toward slightly younger ages of children in substitute care. This youngness may also reflect the improving permanency planning practice of moving children out of foster care either back home or into adoption or guardianship. Many of the youngest children are also in care because of chronic drug abuse by their parent(s). Compared to national levels, California has a greater percentage of Hispanic children in care, reflecting the larger Hispanic population in California. Compared to state population levels, however, Hispanic children (21 percent in care versus 30 percent in the population), and Asian children (4 percent versus 10 percent) are underrepresented in foster care, while black children (29 percent versus 9 percent) are overrepresented.[42]

TABLE 10-5 Gender, Age, and Ethnicity of Children in Substitute Care, in California

	FY 1986
Gender	
Male	51.4%
Female	48.5
Unknown	0.1
Age	
Less than 1 year	3.1%
1 to 5 years	24.0
6 to 12 years	31.8
13 to 18 years	39.6
19 and over	1.4
Unknown	0.1
Ethnicity	
White	45.6%
Black	29.1
Hispanic	21.1
Other	n.a.
Asian/Pacific Islander	2.4
American Indian	1.1
Filipino	0.5
Unknown	0.2

SOURCE: VCIS, data from 40 states. Maximus, Inc., *Child Welfare Statistical Fact Book, 1984: Substitute Care and Adoption.* Foster Care Information Service (FCIS), average monthly figures.

In fiscal year 1983, the national median length of time a child spent in foster care was about nineteen months. Almost a quarter of the children in foster care were removed in less than six months. However, a full 18 percent spent five years or more in foster care. Compared to other major states, California moves children out of substitute care relatively quickly (Table 10-6). During the first quarter of 1987, over half of the children in foster care in California had been in care for six months or less (Figure 10-3). The median number of months spent by California children in substitute care in 1984 was sixteen months, compared to

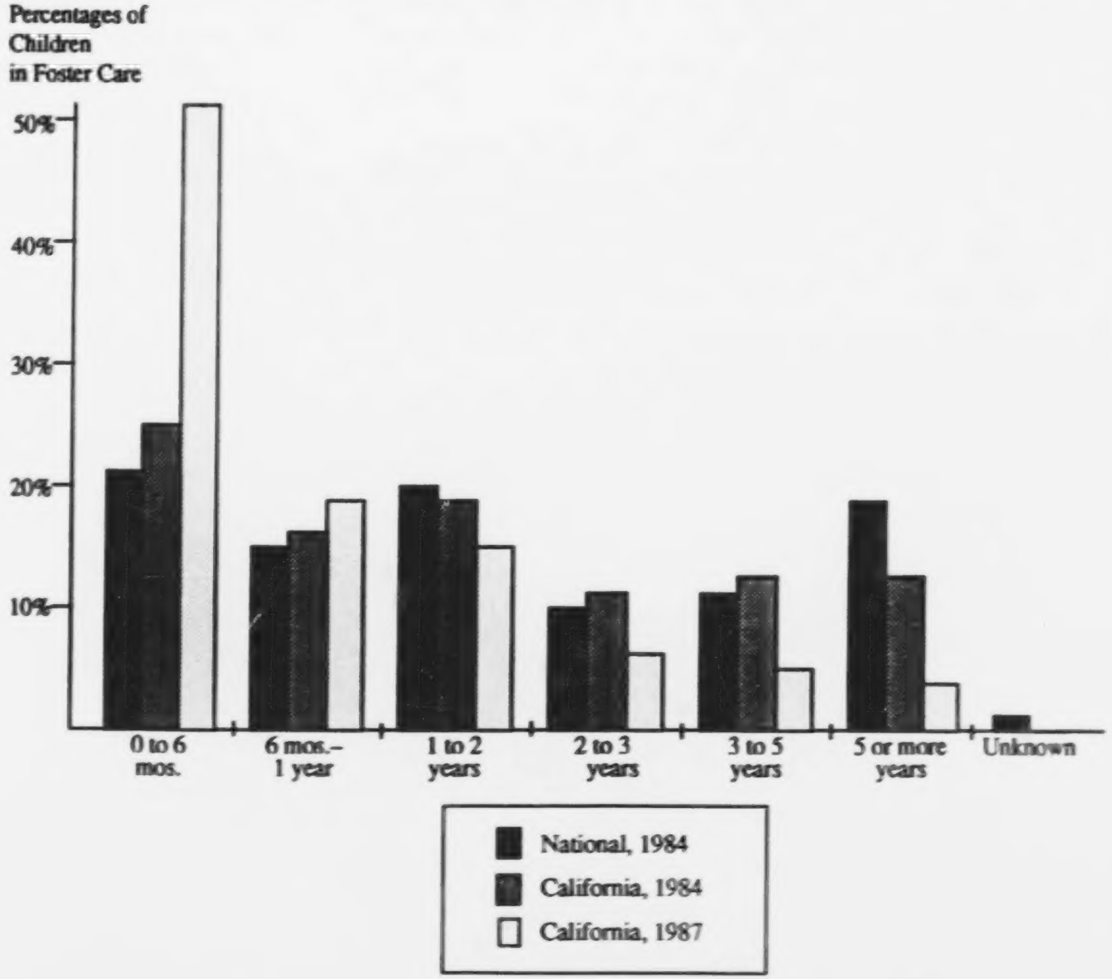
TABLE 10-6 Length of Time in Substitute Care, Five Large States, 1984

	Percentages of Children in Care				
	CA	NY	IL	TX	MA
Number of months					
< 1	5%	0%	6%	1%	3%
1–5	20	10	26	19	14
6–11	16	16	19	19	13
12–17	11	13	13	13	10
18–23	8	9	8	9	9
24–29	7	7	9	6	10
30–35	5	7	3	6	10
36–59	13	15	7	13	9
60+	13	22	8	14	23
Unknown	1	0	0	0	0
Totals	99%	99%	99%	100%	101%
Median (months)	16	25	12	17	25

Note: Due to rounding error, some columns do not total 100%.

SOURCE: Maximus, Inc., *Child Welfare Statistical Fact Book, 1984: Substitute Care and Adoption.*

FIGURE 10-3 Duration in Foster Care, California (1984, 1987) versus the Nation (1984)



SOURCE: APWA, *Characteristics of Children in Substitute Care*, California State Department of Social Services.

twenty-five months in New York and Massachusetts. Yet children in substitute care in Illinois spent only a median of twelve months in care before being returned home or moved into a permanent placement.

In 1984, almost two-thirds of children leaving foster care returned to either their own home or that of a relative (Tables 10-7 and 10-8). By 1987, this number was reduced to 53 percent– a decline of 12 percent. This decline partly reflects greater use of placement prevention services encouraging placements with relatives earlier in the service plan.

In 1987, only 6.5 percent of children leaving care in California were adopted. Compared to other states, California had a small proportion of adoptions and California's foster children were less likely to have a plan of adoption. For example, in 1984 New York placed 17 percent of its children leaving foster care in adoptive homes. (Nationally, 12 percent of children leave foster care through adoption.) This contrast is in some part attributable to the greater likelihood that children in California would already reside with relatives unwilling or unable to adopt them. California was much like other large states in its intention to reunite foster children with their parents (Table 10-9).

TABLE 10-7 Percentages of Children Leaving Substitute Care for Various Outcomes

	National FY 83[a]	California 1983	California 1987[b,c]
Reunited with family or placed with relative	56.3%	65.0%	53.2%
Adopted	11.5	6.0	6.5
Reached majority	9.4	9.0	7.1
Other	20.3	n.a.	n.a.
Ran away	n.a.	10.0	18.2
Guardianship	n.a.	9.0	0.0
Death of child	n.a.	0.0	0.3
Other	n.a.	0.0	13.9
Unknown	2.5	0.0	0.8

[a] Based on 90,332 children in 28 states.

[b] Average monthly figures for January through March 1987.

[c] National FY 1987 data are not yet available.

SOURCES: Maximus, Inc., *Child Welfare Statistical Fact Book, 1984: Substitute Care and Adoption.* Foster Care Information System (FCIS).

TABLE 10-8 Children Leaving Substitute Care in Five Large States, 1984

	CA	NY	IL	TX	MA
Placed in foster home	65%	60%	75%	39%	69%
Adopted	6	17	12	11	7
Emancipated	9	12	5	10	10
Ran away	10	0	3	0	0
Discharged to another agency	0	0	4	18	1
Other	9	11	3	22	14
Unknown	0	0	0	0	0
Totals	99%	100%	102%	100%	101%

SOURCE: Maximus, Inc., *Child Welfare Statistical Fact Book, 1984: Substitute Care and Adoption.*

Although the preference for children in substitute care is to return home or be adopted, a large group of children left foster care in less optimal ways. Nationally, 20 percent of children in foster care experienced guardianship, running away, incarceration, or other outcomes. In California in 1987, a full 18.2 percent of children in substitute care ran away (this figure includes juvenile offenders). Another 7 percent remained in foster care until reaching the age of majority (slightly less than the 9 percent who did so nationally).

According to national data, California uses group homes for substitute care at about the same rate as other comparison states (Table 10-10). These rates are undoubtedly influenced by dissimilar definitions across states. California defines residential care facilities as "group homes." The definition of the emergency shelters as group homes varies widely. Overall, about 20 percent of children in substitute care in California are reported to live in group homes

TABLE 10-9 Placement Goals for Children in Substitute Care in Five Large States and the Nation, 1984

	National Estimate	CA	NY	TX	FL	MA
Family reunification	51%	5%	41%	49%	61%	24%
Adoption	14	11	20	14	16	23
Independence	9	4	27	3	3	9
Long-term foster care	16	22	3	16	20	16
No goal yet[a]	7	10	2	10	0	19
Unknown	3	1	7	7	0	9
Totals	100%	101%	100%	99%	100%	100%

[a] In California, figure includes guardianship (9 percent).

SOURCE: Maximus, Inc., *Child Welfare Statistical Fact Book, 1984: Substitute Care and Adoption.*

TABLE 10-10 Living Arrangements of Children in Substitute Care, 1984, Six Large States

	National Estimate	CA	NY	IL	TX	FL	MA
Foster care/ adoptive home[a]	68%	77%	69%	81%	66%	66%	82%
Group home or child care facility	18	20	25	14	30	19	18
Independent living	1	0	0	5	0	0	0
Other	12	3	6	0	4	15	0
Unknown	1	0	0	0	0	0	0
Totals	100%	100%	100%	100%	100%	100%	100%

[a] Nonfinalized adoptive homes included in California and Illinois.

SOURCE: Maximus, Inc., *Child Welfare Statistical Fact Book, 1984: Substitute Care and Adoption.*

Foster care services are delivered via two programs–Family Reunification and Permanent Placement.

The Family Reunification Program. The Family Reunification Program is short term and designed to return children home or to relatives. Family Reunification services are provided to families of children placed in foster or group care by the court; their purpose is to help the family identify and eliminate the problems that initially required the child's removal. This process is designed to identify the specific actions to be taken by the family and the agency to achieve family reunification. To prevent children from remaining for indefinite periods in foster care, services are limited to twelve months (they may be extended for up to an additional six months by court order). Court reviews must occur at least every six months, with a final permanency planning hearing to decide the child's future conducted no later than twelve months after the initial placement commences.[43]

Admittedly imperfect studies consistently indicate that children in foster care show measurably better developmental outcomes than their abused and neglected counterparts who remain home. The children who stay at home also have poorer school attendance and educational performance, a lower degree of social adjustment, and more frequent police contact as compared to children remaining in foster care.[44] These outcomes have not been compared across a lifetime, and the advantages of out-of-home care may erode over the years. It appears, however, that family reunification as typically practiced across the states and in California fails to protect children in the short run.

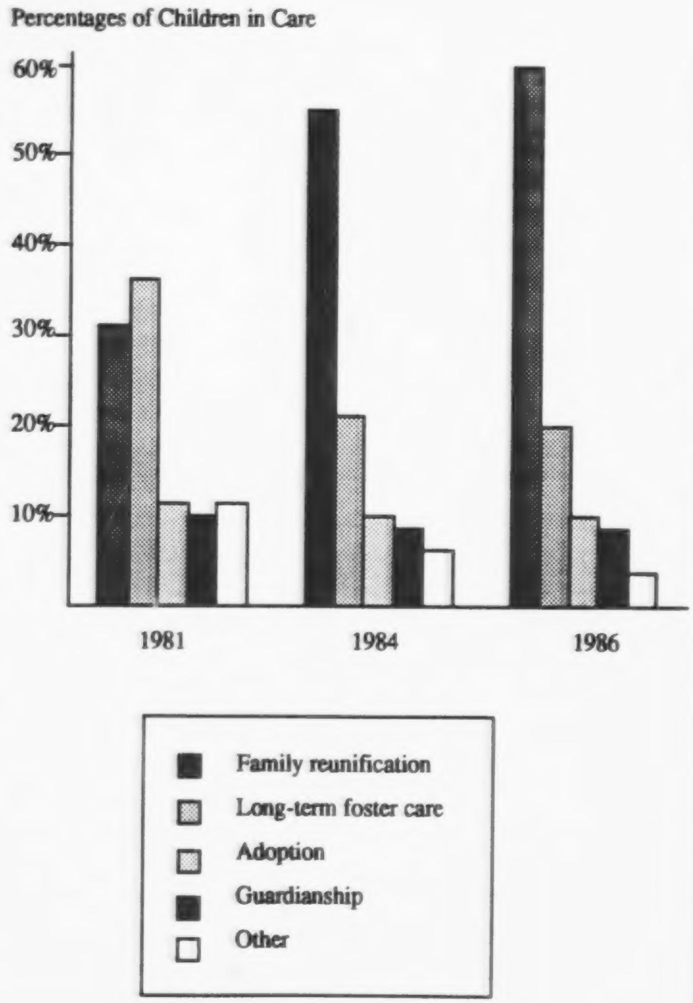
The Permanent Placement Program. Children who need an alternate family or residence because the threat of repeated abuse, neglect, or exploitation precludes either remaining or returning home, are served by the Permanent Placement Program. Alternatives to be considered include adoption, guardianship, and long-term foster care, in that order. Placements of children in these programs receive administrative or court reviews at least every six months.

Although the hazards of foster care have been grossly overestimated,[45] children who remain in long-term foster care may indeed experience difficulties. They often move from home to home; as they get older, their yearly re-placement rates approach 50 percent.[46] These children may often experience educational lags and subsequent employment problems.[47] They are prone to homelessness when they age out of foster care at 18.[48] Exposure to foster care does not doom a child to a distressed adulthood–indeed, it may provide the child with beneficial developmental experiences not found in the birth home. Nevertheless, especially when compared to children who leave foster care via adoption, children who grow up in foster care appear to be at risk of short-changed futures.

In keeping with the goals of SB 14, plans for children to remain in long-term foster care have fallen from 37 percent of case plans in 1981 to 21 percent in 1984 and 19 percent in 1986 (Figure 10-4).[49] This may be partly attributable to the increase in new cases in recent years, since new cases often begin with hope of reunification. It is certain, however, that family reunification is also planned considerably more often than it is achieved. Adequate estimates of reunification rates are impossible to acquire at this time. Especially needed are indications of the typical point of no return, after which children are most unlikely to go home and should be reviewed for adoption. Without adequate counts and real-time data, the reunification program sails on without a rudder of evaluation.

The Quality of Foster Care. The quality of foster or group care is a key determinant of a child's well-being. Foster parents are increasingly difficult to recruit and maintain. Foster home recruitment efforts are not keeping pace with increases in the number of children in foster care. In Los Angeles County, the number of available foster beds increased by 16 percent between 1984 and 1987, whereas the number of children in placement

FIGURE 10-4 Case Plan Goals for Foster Care Children in California, Selected Years



SOURCE: Legislative Analyst.

increased by 42 percent.[50] Increased payments to foster parents have been shown to improve a state's ability to find good homes and to find homes for more difficult children,[51] yet California's cost-of-living adjustments (COLAs) to foster parents have averaged only 1 percent increases per year since 1982. In some areas, people pay more to board healthy dogs in kennels than foster parents receive to care for abused children.

The costs of resources to orient and train foster parents are minimal when compared to the alternatives of hospital or group care. The numbers of drug-exposed babies remaining in hospitals because they cannot find foster families grows steadily in urban counties. Increased funding for foster care and greater availability of respite care could help restore the attractiveness of the foster parent role. Without such a commitment, the quantity and quality of foster parents will continue to decline as the numbers and needs of children increase.

The success of the foster care program rests in great part on the foster parent population. Although statewide data are not collected on the characteristics of foster parents, a recent random sample of 100 foster parents in the San Francisco Bay Area found that 78 percent were 40 years old or older, 40 percent were not married, 40 percent had a high school education or less, and 16 percent received income assistance. Evidence from other states suggest that the proportion of foster parents under the age of 50 has been declining steadily over recent years. Foster parents are "graying," yet foster children are growing younger and often need long-term care. The long-term capacity of foster parents to continue to adopt many of the children placed with them is dubious. Renewed efforts to make foster care appealing to men and women ages 20–50 are needed to maintain the quality of foster care. Inadequate COLAs and insurance problems have disheartened many foster parents. Foster parent training and new federal monies to provide independence skills training programs for foster parents and foster youth have not yet provided sufficient incentives to improve foster parent recruitment.

Current gaps in child welfare services for older children will widen as the population of foster children currently in long-term care ages. Older children are in care longer and in increasingly restrictive placements. Promising programs have been developed in other states to facilitate more family-like placements of adolescents.[52] Still, efforts should be made to speed up the process by which foster children who cannot go home are freed for adoption. California's foster-adopt programs should also be continued.

In California, young people in foster care must leave foster care at the age of 18 (if they are not in their last year of high school). They become "emancipated." Foster children often call this the "E-word" because they recognize the unspeakable difficulties of surviving in California's tough housing and job market with no support. California's recent graduates from foster care, if they are like other foster children in a recent national study, have typically not completed high school (67 percent) and have no job (79 percent).[53] Only about one-fourth of soon-to-emancipate foster youth are on an employment or educational track that will eventually lead to jobs paying more than minimum wage. These youth are sad but determined, unskilled at money management, and—especially among the young women—prone to enter into emotionally, physically, and financially abusive love relationships. Fewer than one-half of the youth discharged will have had preparation for independent living. Additional independent living services newly funded at the federal level will help prepare more youth, although this preparation provides no guarantees that these youth can manage the financial and personal challenges needed to continue their educations. Other states continue to provide foster care for youth up to the age of 21 if they are in school. The future of California's current foster children would be brighter if this provision were extended to them.[54]

Adoption

The four basic avenues for adoptions are public agency, private agency, independent, and intercountry. Public agency adoptions (usually of older children previously in foster care) decreased greatly from 1970 to 1978, and then leveled off at about 1,600 children each year. Since 1980, public agency placements have increased 28 percent from 1,685 to 2,285 (Table 10-11). These increases exceed child population increases in California. Private agency adoptions (which involve children—both infants and older children—not previously in foster care) exceeded 1,400 per year in 1970 and have decreased sharply since. Approximately 450 children have been placed by private agencies in California each year since 1980. Independent adoptions (usually of infants) are arranged without an agency; they increased sharply after a lull in the late 1970s. Since 1980, they have increased 40 percent. Nevertheless, more children are placed through public and private agencies than independently each year. Adoptions of children from other countries have more than doubled since 1980.

From requests for information about adopting to applications for adoption to approval of homes, the number of eligible adoptive applicants in 1985–86 decreased from 23,611 to 2,173. Although public agencies received 13,591 requests during the year, only 5,909 (43 percent) applications were filed, and only 1,580 (12 percent) were used for adoption. In addition, the 75 percent attrition rate from application to adoption demands further study. Private agency adoptions reflect even more winnowing, with 9,190 requests received, 809 (9 percent) applications filed, and 517 (6 percent) homes used. No data are available on the number of potential adoptive families who pursue independent adoptions. Nor is it possible given existing evidence to compare outcomes for children in independent and agency adoptions.

Of children in foster care referred for an adoption eligibility assessment by county agencies, only 30 percent were recommended

TABLE 10-11 Children Placed for Adoption in California, 1980–81 to 1985–87

Fiscal Year	Public Agency	Private Agency	Total	Independent[a]	Intercountry
1980	1,685	608	2,293	1,646	194
1981	1,704	464	2,293	1,649	223
1982	1,704	449	2,158	1,823	288
1983	1,451	422	1,873	2,000	300
1984	1,776	399	2,175	1,828	291
1985	1,941	401	2,342	2,033	348
1986	2,152	447	2,599	2,220	452
1987	2,285[b]	394[b]	2,679	2,396	485[b]

[a] Court reports filed and approval recommended.
[b] Children placed but adoptions not yet finalized.

SOURCE: Statistical Services, State of California.

for adoption during 1985–86. This low level is principally due to lack of available adoptive homes, although some children are ineligible for other reasons.

The median age of children when taken under care by public adoption agencies has increased slightly, as has the median age at actual placement (Table 10-12). These modest numerical increases are rather significant given the sharply reduced likelihood of finding an adoptive placement as children age in foster care. Males and females are about equally represented among adopted children. White children make up about half of the adopted population. Hispanic and black children have had slight increases in adoptions since 1980–81. Compared to the population in general, children in public agency adoptions were much more likely to be Asian or black and much less likely to be Hispanic. Compared to general rates of adoption of children in foster care, Asian children were more likely to be adopted and black children were least likely. Sibling placements (placing two or more siblings together in the same adoptive placement) have increased to 31 percent of all adoptive placements. An increasing proportion of children in adoption have at least one special problem, such as emotional and/or behavior problems, physical disabilities, medical conditions, or mental retardation. The percentage of children in adoptions with such problems has increased from 30 percent in 1980–81 to 47 percent in 1983–84, reflecting the increase in adoptions of older children. Adoptions by foster parents have increased from 39 percent of public agency adoptions in 1980–81 to 63 percent in 1985–86 as agencies have given preference to foster parents in order to maximize the continuity of children's care. Adoptions by foster parents are considerably more stable than adoptions by new families.[55]

During 1985–86, the number of children in California who were legally free and awaiting adoption (2,154) was slightly less than the number placed for adoption during that year (2,599). The number of additional children freed during the year totaled 2,388. County adoption agencies placed the majority (79 percent) of children in agency adoptions that year. Even these data are deceptive, however, as many children wait for adoptive homes because agencies often do not free children until they have an adoptive home ready to assume their care.

The number of foster children who really need adoptive homes is far greater than the number who are freed and not yet placed. Anecdotal reports from agencies indicate this is especially the case for black male children. Agencies have stepped up efforts to find homes for minority children, but black children still wait for adoptive homes, while Asian and white children seldom wait long

TABLE 10-12 Yearly Trends in Public Agency Adoptions

	1980–81	1981–82	1982–83	1983–84	1984–85
Median age (months) when taken under care	25	26	23	31	n.a.
Median age (months) at placement	45	48	48	56	n.a.
Sex					
Male	55%	54%	53%	52%	50%
Female	45	46	47	48	50
Ethnicity					
White	49%	48%	50%	45%	44%
Hispanic	12	14	12	16	15
Black	13	13	11	12	15
Asian	1	1	1	1	1
Other	1	1	—	1	1
Black-white blend	6	5	5	6	5
Hispanic-white blend	7	7	9	8	8
Asian-white blend	1	1	2	1	1
Other blends	10	10	10	10	10

	1980–81	1981–82	1982–83	1983–84	1984–85
Foster parent adoptions	39%	41%	43%	58%	58%
Sibling placements	20%	22%	21%	28%	28%
White parents adopting Minority children[a]	26%	23%	22%	28%	n.a.
Black	1	1	0	1	n.a.
Hispanic	4	6	3	7	n.a.
Other	2	1	1	1	n.a.
Black-white blend	2	2	1	2	n.a.
Hispanic-white blend	6	6	8	8	n.a.
Other blends	11	7	9	9	n.a.
Prior adoptions	9%	8%	7%	6%	5%
Child has one or more special problems	30%	34%	37%	47%	43%

[a] Percentage reflects the percent of transracial adoptions within all white parent adoptions.

SOURCE: Barbara Mason, *Characteristics of Relinquishment Adoptions, 1980–81, 1981–82, 1982–83, 1983–84, 1984–85.*

for adoptive homes. Less than 1 percent of black children are adopted into nonblack homes. Such transracial adoptions are rarely considered by practitioners in California. Instead, black children remain in foster care even when adoptive homes are available. Throughout much of the state, and especially in Los Angeles, available parents and children of all races wait for adoption services to make placements.

California has been a leader in providing subsidies to families in order to facilitate adoptions of special-needs (that is, older and/or more troubled) children. California's subsidy program was a forerunner of the current national subsidy system. Adequate subsidies promote adoption by reducing the disincentive of lost income for foster parents who are considering adopting a foster child. Since subsidies were instituted, foster parents have become likely adoptive parents. Recent evidence from adoptive parents in California suggests that subsidies have a strong positive effect on reducing the difficulty of adjustment among older child adoptions.[56] In 1986–87, the average adoption subsidy was $318.42 per month per recipient.[57]

Adoption provides lasting homes for children who cannot return to their birth home. Adoptive families provide an abundance of personal and financial resources through adolescence and into adulthood. Children adopted when older typically adapt successfully in terms of mental health, attachment capacity, and self-esteem.[58] Studies comparing foster children and adopted children as adults indicate that the educational attainment of foster children is well below that of adopted children.[59] Although direct contrasts must be made with restraint, former foster children attend college at a rate that is one-fourth the national average whereas adopted children graduate from college at a rate exceeding the national norms.[60] The commitment of adoptive families to their children is intense and lasting—two characteristics that help redress many of these children's early troubles.

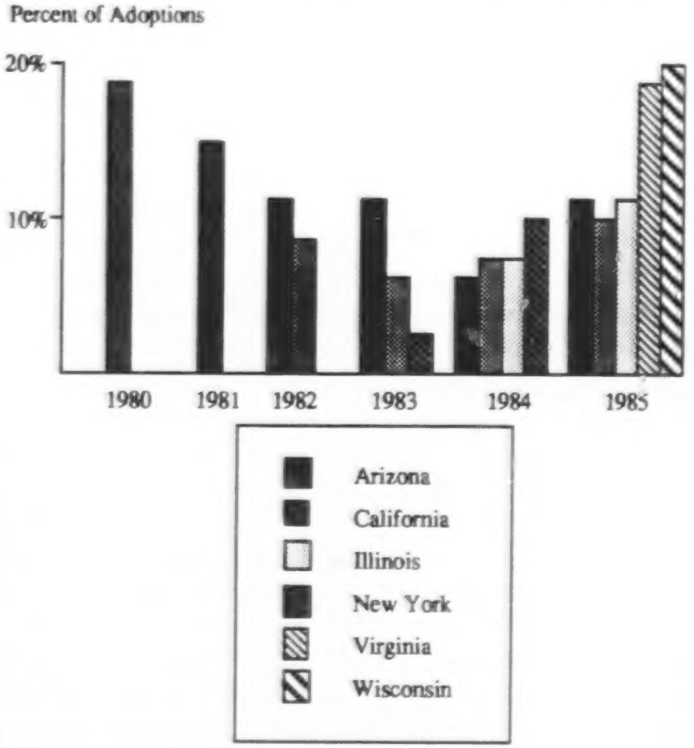
The 1980s have reduced obstacles to adopting older children. Such obstacles include costs for special medical, educational, and psychological services; policies against foster parent adoptions; and the disqualification of children as adoptive candidates because they are adolescent, handicapped, or have failed in other adoptive placements. As a result, adoption rates of older children in California have begun to rise. Still, only about 10 percent of children in foster care every year are recommended for adoption, and only about 6 percent are actually adopted.

Adoption is a strong ally of a child's development. Providing a new family is the most comprehensive intervention our society offers children. Yet some placements fail to provide adequate satisfaction for the child or parent(s) or both. In such cases, the child may be returned to foster care or group care. From 1980 to 1984, California had an adoption "disruption" rate of roughly 10 percent (Figure 10-5).[61] This compares favorably to an estimated national disruption rate of 13 percent.[62] In 1985, Wisconsin reported a rate of 20 percent, Virginia reported 19 percent, Arizona 11.3 percent, and Illinois 10.7 percent. California appears to take a rather conservative posture about adoptions of older children, although California's high use of foster parent adoptions means that many adoptions that are planned but not completed are not included in this rate.

Adoption of older children under permanency planning appears to be highly beneficial, but is still rarely used in California. Fear that adoption disruption rates are escalating under permanency planning are unfounded. Older child adoptions are generally quite satisfactory and stable. If California provides more lasting postplacement and postlegal services to families who adopt special needs children, the incidence of disrupted adoptions may further decline.[63] The positive developmental outcomes of adoption and children's satisfaction with it are, on the whole, consistent with current policies to support its use. Yet California currently lags behind other states in placing older children in adoption.

Recent research in California indicates that single-parent, transracial, and small sibling group placements are as stable as conventional placements.[64] If this knowledge is used to increase

FIGURE 10-5 Adoption Disruption Rates in Major States, 1980 to 1985



SOURCES: Urban Systems Research and Engineering, Inc., *Evaluation of State Activities with Regard to Adoption Disruption.* R. P. Barth, M. Berry, R. Goodfield, and M. L. Carson, *Older Child Adoption and Disruption.*

the use of such placements, adoption might again rise. More importantly, courts and agencies must move more expeditiously to terminate parental rights when the child cannot return home, so that children are free for adoption while they are still young and attractive candidates. Efforts to find more adoptive homes need to be expanded.

Despite recent policies to eliminate barriers to adoption, some children are still routinely deemed unadoptable. Black children in all counties are least likely to be adopted even though, proportionately, black families adopt more children than other California families. Research on disruption of the adoptive family is beginning to provide clearer guidelines on the children most likely to succeed in adoption, as well as the elements associated with stability. If policy were informed by this research, more comprehensive and consistent application of eligibility and adoptability assessments would result.

Adoption is clearly more effective in promoting the well-being of children than is foster care. The average resources provided to adoptive children are far greater than those provided to foster children. Those resources are primarily offered by the family and not by the government. Although the total resources provided to the adopted child are almost four times those provided to the foster child, the amount provided by the agency or government is about one-half. Thus, while the purely economic costs of adoption exceed those of foster care, the great majority of those costs are borne by the family. The benefits of adoption that result from greater educational investment and economic success surpass those of foster care by at least $240,000. The lifetime financial value of adoption to the child exceeds that of foster care by more than $460,000. Although public agency adoptions are not made on the basis of their financial value, and love is the far more important currency, financial welfare is important to children. The observations of a California child welfare administrator seventy years ago are still accurate today:

> Each child is born with the right to a home, which is paramount to the parents' right to the child, when they do not provide a fit home. . . . The same money now spent in too many institutions, were it invested in child placing, in sifting through investigation, and in after-care, would bring to the kind-hearted and generous ten times as much real satisfaction, and to the children and the state tenfold as much good.[65]

Children's Preferences

Children are most satisfied with and best cared for by child welfare services when their original family is preserved or they are given a permanent new family. Although too little is now known about children's preferences, some data are available. A child's perception of permanence is highly associated with his or her satisfaction.[66] To those children who have had multiple placements and seek a sense of belonging, adoption is preferred. In a study of foster and adopted children, 22 percent of adopted, formerly foster children perceived foster children as not being treated as well as other children.[67] In a study that interviewed foster children judged unlikely to return home, half wanted to be adopted even though they were older children removed from their home at an older age.[68] They expressed their wish to belong to a real family. Legal guardianship is often considered a preferable alternative for older children who have lived for a long time with a foster family or relatives, do not want to be adopted, and cannot go home. Unfortunately, virtually nothing is known about the safety and longevity of guardianship.

Although adoption is often preferred, foster care is generally reported by children to be positive. Fewer than half the foster children in a West Virginia study reported that they were treated differently from other children because they were in foster care.[69] A major study of foster children found they were significantly more attached to their foster homes than to their birth homes.[70] Life in residential care has somewhat less appeal. Children living in institutions felt less comfortable, less happy, less loved, less trusted, less cared for, and less cared about than either children in other forms of surrogate care or children reunified with their families.[71] A recent study of youth who left foster care in California in the last ten years found that 68 percent agreed they were somewhat or much better off than they would have been if they had remained in their birth homes.[72] Clearly more research is needed to better understand what contributes to children's satisfaction with placements. This need is especially dire considering the high rate of children who run away from substitute care in California.

Conclusions

The increase in reports of child abuse has strained the child welfare system. Almost two out of three families reported for child abuse receive no services. These families include many families in potentially dangerous situations and at risk of arriving at crisis status. Most counties admit that they do not have resources to meet the demands of either the law or needy families. Although the numbers and proportion of abused children who are served at home have increased, services to these families have not. To date, few preventive or early interventive services are provided. The practice of foster care grows accordingly.

An early evaluation (1985) of the effects of SB 14 found that, while legal requirements were generally met, program changes to increase placement prevention services were generally not implemented.[73] The 1985 report did find that SB 14 initially helped to abate the flow of new foster cases and increased the incidence of foster care children reuniting with their parents. These improvements have apparently eroded under continued increases in child abuse reports.

The implementation of SB 14 continues to be quite gradual. A more recent assessment by the California Senate Select Committee on Children and Youth concluded that:

> Given existing resources the system cannot adequately investigate all cases, offer services to prevent the removal of children from their homes, attempt reunification of abused or neglected children and their parents, develop permanent plans for children who cannot be returned, and try cases expeditiously. In too many instances, the wrong cases are being acted upon, while other serious cases are going untreated. Many experts feel that the nature of abuse cases is becoming increasingly severe. The number of children in foster care continues to rise.[74]

In March 1987, The Little Hoover Commission also evaluated the effects of program changes resulting from SB 14 and found that programs are fragmented and compartmentalized across the state. "The complexities of the system, the unclear roles and responsibilities, and the fragmented delivery of services, have a negative impact on the cost-effectiveness of the services being provided."[75] These separate evaluations demonstrate that delivering services to abused children continues to be a significant challenge to the state and deserves review and renewal.

Data on child welfare services do not allow an adequate description of the conditions of children and child welfare services. The state of California currently participates in the voluntary national Foster Care Information System (FCIS). The FCIS was a major source of data for this chapter and represents a great leap forward in data resources. In the not-so-distant past, this chapter could not have been written at all. Still, because of its drawbacks, this system cannot support reliable conclusions about the conditions of children in the child welfare system. For example, the FCIS keeps track only of children receiving AFDC-FC (foster care) payments, and therefore does not include children in voluntary family maintenance, many emergency shelter facilities, and state-funded foster care. Secondly, data are reported monthly for each child currently in substitute care, but without specific indicators of the child's movement through the child welfare system. The result of the lack of monthly counts accompanied by status markers is that case plans cannot be distinguished according to the child's status. So we know that adoption is the plan for only 10 percent of all children in substitute care, but we can only hope that adoption is the plan for a larger proportion of children who are past their permanency planning hearing. Without such markers as to the child's status in the system, we do not know whether or not services are changing in the direction of the law's intent and leading to more adoptions for children unable to return to birth families. The expeditious development of a statewide data management system that tracks individual children across time and services is crucial.

Estimating the success of child welfare programs requires redressing the paucity of data on the conditions of children in and out of the child welfare system. A child welfare information system that follows children individually is an essential starting point. Linkages to the education and health care database must follow, because these are the two domains in which children in the child welfare system suffer the most deficiencies. Such linkages would allow evaluation of the capacity of services to promote learning and health.

California's recent child welfare reforms seek to (1) identify and protect more abused children, (2) reduce out-of-home placement, (3) shorten the time children spend in foster or group care, (3) reduce the number of children in long-term foster care, (4) achieve these reductions through family reunification and adoption, and (5) keep better track of the movement of children through child welfare services. In many ways, the reforms are still being implemented. Los Angeles County's new (April 1986) twenty-four-hour response system was a striking, if belated, success in increasing placements of children in the extended family, rather than in foster care families. The program attests to the many unfulfilled possibilities of the initial reforms. More vigorous in-home and adoption services (just now effected by the 1982 reforms) promise additional benefits to children.

A few goals, however, have been achieved. Perhaps the most important of these is identifying more children in need of protection. Violence against children is no longer simply a family matter– public awareness is greater, and services are more available for children in need. Increased reporting rates have resulted in more children in all parts of the child welfare system. The number of children removed from their homes has also seen an increase, although over half of these children do return home, usually in less than six months. Decreases in time spent in care are partly due to the practice of returning more foster children home.

A question concerning the effects of these achievements now faces policymakers: more children are being returned home and in less time, but at what cost? Lacking preventive and family maintenance services, children too often return to a hazardous home life. Family maintenance programs that are limited to court-adjudicated services and a six-month time span face heavy odds in the attempt to strengthen family resources. Most family maintenance services provide counseling, but not concrete resources such as teaching job, homemaking, or parenting skills. Homeless children and families still do not have a predictable place in the child welfare service system. Although average length of time spent in care and numbers of children in care have been reduced, this decline is due primarily to family reunifications, which are too often volatile and unstable. Adoption, however, is more permanent but less common. Looked-for increases in the proportion of children in the child welfare system placed for adoption have not materialized.

Sharp increases in California's use of foster care reflect the many hazards children face in many of California's homes and families. Although improved preventive and adoptive services could lessen the numbers of children in foster care, the conditions of the children in foster care are not the gravest concern– at least foster children receive some corrective medical, educational, and counseling services. The abused and neglected children who are not receiving any services experience the gravest threat. With improved foster parent training, new services to promote independent living skills for adolescents, and more careful administration of the long-term foster care program, foster care is a crucial resource for our children. Assuming no changes in existing services, and assuming that homelessness, substance abuse, and child abuse and neglect remain at the current level of severity, reductions in foster care would almost surely signal a reduction in the quality of children's lives. Increases in foster care are most troubling because they signal the gross failure of so many families to provide minimum protection for their children.

Recent increases in the percentage of children in poverty in California are undoubtedly related to the increased demand for foster care. Although child abuse occurs across the socioeconomic spectrum, poverty greatly increases the risk. The most effective public assistance, drug treatment, education, employment, and housing programs would not eradicate the need for child welfare services, but they would certainly reduce the demand for substitute family care. Many families find themselves in situations where they are unable to care for their children. Their need for foster care greatly depends on their ability to obtain resources and the likelihood that those resources will be sustained for sufficient time to provide an acceptable window of safety for the child.

In the first White House Conference on Children, the family was called "the highest form of civilization." Children who live in abusive families do not share this view. Since abusive families have come to their attention, service providers have had the opportunity and responsibility to devote several years of continuous effort to improving family life. However, even a loving family cannot protect homeless and impoverished children from harsh and handicapping conditions. Current services appear to doom these children to living in the worst conditions of fear and deprivation.

Child abuse is one of the earliest manifestations of family circumstances that may lead to a range of educational, criminal, and health problems, including aggression, school failure, poor health, substance abuse, and delinquent behavior. Thus, interventions to reduce child abuse, if they address the social and ecological threats to the child's and family's welfare and promote parental capacity, also contribute to reductions in related difficulties. The direct contribution of child abuse to a child's future problems is difficult to distinguish from the influence of other factors in the family and community environment. Still, interventions that follow from reports of child abuse may help to redress additional problems that families and children suffer.

Child welfare services provide protection to more children than ever before in California. Our ability to monitor and review the progress of services to children has advanced. The remaining challenge is to go beyond child protection to promote acceptable levels of care for children inside and outside the formal child welfare service system.

Chapter 11

Children, Delinquency, and the Law

By Thomas G. David
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The authors of course take final responsibility for the chapter.

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Troubled and troublesome youngsters[1] have occupied the attentions of public authorities and the general public since the earliest days of statehood in California. Over the last century, dramatic changes have occurred in the kinds of behaviors sanctioned by law, in the policies and agencies designed to deal with youthful offenders, and in the consequences for young people[2] of involvement with the formal legal system. These shifts themselves reflect more general legal and cultural transformations in the expected activities and acceptable routines of childhood and adolescence.[3] Today, powerful media images again portray an upsurge of violence and crime among youths. Some politicians and other public voices call for more punitive responses to juvenile offenders. The formal juvenile justice system—county probation agencies, juvenile courts, and county and state detention facilities—is beleaguered and overburdened; at the same time, incarcerated youths face overcrowded conditions and unprecedented levels of violence *within* county facilities and California Youth Authority (CYA) institutions. Much in the current relations between youths and the law and in the situation of the institutions comprising the juvenile justice system, however, is familiar in outline, if different in particulars, from past relations. Current issues affecting the juvenile justice system and its wards—the politics of competing philosophies and practices of justice, serious overcrowding in state and county detention facilities, and a dearth of resources—have historical antecedents, present implications for youths, and future consequences. Initiatives taken or foregone in the coming years will affect the experiences of California children, and that public institution called the juvenile justice system, for some time to come.

To examine the conditions of youth in California in relation to the juvenile justice system is at once to focus on indicators of juvenile delinquency and to consider the experience of young people detained in county or state facilities, many as wards of the state. In either case, the conditions of the system—its guiding premises, positions, and practices—are relevant. Most policy discussions focus *only* on the characteristics and conditions of the justice system. Often absent in these analyses are discussions of the conditions and experiences of young people themselves—discussions at the "system" level may be convenient summaries for policy purposes, but they can also obscure the lived consequences of policies. In this chapter we attempt to broaden the discussion to consider how aspects of the law are consequential for the children and youth who encounter them. We first review the legal status of children and youth, outline some structural characteristics of the current system, and provide a brief historical survey of its development. Then we discuss recent trends in available evidence on delinquency. In later sections we review information about youth currently in the different sectors of the justice system—data on who they are, how they came to be there, what their experiences may be, and the individual and societal consequences of these arrangements. Finally, we also treat information about recent gang activity in communities across the state and look at available data on children as victims of crime. Like authors of other chapters, we are limited by systematic data on the conditions of children and hindered by often profuse but partial administrative data for sectors or components of the system.

Children as Juveniles

As childhood has evolved in the United States and in California as a conceptual and organizational category, so also the legal status of children and youth has changed. Statutory definitions of majority and minimum age for various rights and responsibilities are products of the legal and political culture in the United States and their particular history in California.[4] As in most other states today, the age of majority in California is 18 years.[5] Hence, the data and discussion in this chapter pertain to those individuals legally defined as *juveniles* or *minors*.

The legal doctrine of *parens patriae* empowers the state to act as parent to a minor under certain conditions. The state acting as parent provides part of the rationale for a special juvenile justice system, one with the interests of the minor as a basis for state intervention. That rationale, however, implies a responsibility as well, that the state ensure the physical security and well-being of a minor in its care, exemplified in the Welfare and Institutions Code (WIC) provisions that define a young person as a ward of the state in particular circumstances. Landmark judicial precedent and decades of prison and juvenile justice reform have established that incarcerated people shall not be subject to further threats to their physical well-being or safety while in the care of the state.

What Is the Juvenile Justice System?

The juvenile justice system in California receives people under 18 years of age who have either violated criminal statutes or have committed "status offenses."[6] The juvenile system differs from the adult system in the types of offenders received, the manner in which they are processed, and their disposition.

Current Organization of the System

Today, juvenile justice in California is a collection of law enforcement agencies, courts, prosecution and defense agencies, probation and parole departments, correctional institutions, and related community-based organizations. The system is organized around probation departments at the county level, connected to a myriad of other state, county, and municipal agencies. At each level, many of these are functionally separate bureaucracies, a situation creating both benefits and also extraordinarily complex difficulties in practice. These arrangements led one observer to note that juvenile justice "is not an integrated or coordinated system, but rather a collection of agencies tied together by the processing of juveniles offenders."[7] Moreover, the discretion built into the juvenile justice system means that quite distinct *county* legal cultures may affect the disposition of cases. In other words, such standard practices as exist may be interpreted and implemented differently in different counties. Some counties have a model of "coordinated services" (which link prevention programs, corrections, and probation programs with other social support services); in others, the juvenile corrections system is essentially uninvolved with other youth services. Moreover, some counties have no local facilities and commit wards directly to state facilities; the existing state financial reimbursement structure encourages this procedure. Juvenile court judges and chief county probation officers from around the state recently met to discuss these and related topics.[8]

Despite the separation by function, governmental level, and authority, the juvenile justice system is a de facto policy system. "Systems" perspectives on areas of public policy such as the juvenile justice sector have proliferated in recent years. Such an approach helps explain the interconnections among the varied levels of government, kinds of public and private agencies, and various professional groups and individuals that make up what we can somewhat casually refer to as the juvenile justice system.[9] Enormous structural complexity is found at both the county and state levels. In what may be an extreme but illustrative example, a mid-1970s system chart of the Los Angeles County Probation Department reveals a total of 138 decision points in the processing of youth and the administrative forms accompanying these procedures.[10] Moreover, a typical state juvenile justice system may have a dozen or more system functions (such as police station intake, detention hearing, and transfer to nonjustice institutions), with scores of decision options at successive points (such as counsel and release, dismiss, and certify to adult court).[11]

A Fundamental Paradox. A fundamental paradox exists in California today. Many indicators and measures of criminal activity among California youth have posted steady declines since the early 1970s. Yet, during a period in which indices of crime have shown declines and the relevant age population has decreased substantially, the youth population incarcerated in state and county facilities shows substantial and continuing increases, as do such other system indicators as the average period of incarceration in such facilities, the length of probation, and the average probation load. These trends reflect the administrative, political, and philosophical changes that underlie the widespread debate about juveniles, the law, and the state that is current among California citizens and across the nation.

Controversies over competing perspectives on justice— such as guiding philosophies that stress the criminal responsibility of the youth or those that emphasize rehabilitation and individual liberties— are not simply contests of empty rhetoric. As the balance between more retribution-oriented and more rehabilitation-oriented philosophies shifts and is translated into the structure of the justice system, these political and ideological decisions effect the disposition of juvenile offenders. In California, for example, patterns of arrest, referrals to probation or juvenile court, and confinements changed following major legislative reforms in the late 1970s. Furthermore, the size and directions of these changes were shown to vary considerably across county jurisdictions within the state.[12]

California incarcerates a higher proportion of its juvenile offenders than do other states with comparable large and heterogeneous youth populations (Table 11-1). Federal statistics indicate that on any given day as many as 430 per 100,000

TABLE 11-1 California Juvenile Arrests Reported 1975, 1980, 1985

	1975		1980		1985	
Arrest Category	Number of Arrests	Juvenile Percentage of Total Arrests	Number of Arrests	Juvenile Percentage of Total Arrests	Number of Arrests	Juvenile Percentage of Total Arrests
Felony[a]	127,842	32.5%	97,621	26.2%	73,521	17.8%
Misdemeanor[b]	156,971	16.3	157,217	13.2	131,667	10.3
Status Offense[c]	86,137	100.0	32,032	100.0	25,773	100.0
TOTAL	370,950	25.8	286,870	18.0	230,961	13.5

[a] Includes homicide, forcible rape, robbery, aggravated assault, kidnapping, burglary, theft, motor vehicle theft, forgery, arson, and drug law violations.

[b] Includes assault and battery, petty theft, drug law violations, drunkenness, DUI, and others.

[c] Actions that are offenses only when committed by a juvenile (such as truancy, running away, incorrigibility).

SOURCE: Bureau of Criminal Statistics and Special Services, California Department of Justice.

California juveniles are incarcerated, a rate twice the national average. By comparison, the rate (per 100,000) is 230 for Ohio, 125 for Texas, 170 for Michigan, and 126 for Illinois.[13] Moreover, in 1985 a one-day federal census counted 12,524 juveniles incarcerated in California, more than four times as many as the next highest state and nearly one-quarter of the national total.

There is widespread recognition among both supporters and critics of the current situation that California has come to rely on incarceration more than many other states in recent years; they even agree on how these arrangements came to be, as we describe later. Disagreement becomes sharper in the assessment of current policies and practices— their utility, costs and benefits, and long-term consequences for both individual youth and the general community— and this disagreement reflects the competing, historic tensions embodied in the California system (rehabilitation versus punishment, costs for other social services, and so forth). To examine why and how this has come to be the case during the 1980s is a useful exercise, in part because it helps in understanding what the consequences of current practices may be in future years. To do so, we first summarize the origins and growth of the current arrangements, then summarize recent policy initiatives that have generated the present situation.

Juveniles do commit serious crimes that require a societal response. Yet a 15-year-old semiliterate burglar still has his life ahead of him, even after a substantial period of incarceration. What is the best response? No consensus exists among the public or policymakers on what might constitute an improved juvenile justice system. Public opinion polls show that although the general public wants the courts to be less lenient, they continue to endorse treatment and rehabilitation as the primary purpose of juvenile corrections.

Competing Philosophies: Rehabilitation and Punishment. In principle, the rationale for the juvenile justice system rests on three competing and often conflicting perspectives: a belief (1) that the youthfulness of juvenile offenders signifies the possibility of rehabilitation, and the related concern that the treatment of juvenile offenders should be more flexible than the standardized treatment of adult offenders, (2) that juveniles should not be in the same facilities as adults, and, of course, (3) that protection of the community is as important as protection of the juvenile miscreant. Rehabilitation of the juvenile offender remains the guiding philosophy among most practitioners and policymakers in the juvenile corrections field. Critics assert that the treatment approach has failed and instead argue that punishment of the juvenile offender and protection of the community should be the central orientation of the juvenile justice system. The concern for victims' rights has also stimulated a new emphasis on accountability and restitution programs. Even supporters of the Juvenile Court agree that it has often failed to live up to its guiding rhetoric, though they suggest that fiscal constraints brought on by tax-cutting initiatives such as Proposition 13 in California and federal budget reductions have crippled juvenile programs. Moreover, they question whether the punishment ethos of the adult corrections system has demonstrated more effect in reducing recidivism.

History of the California Juvenile Justice System[14]

The juvenile justice system in its present form is relatively recent. From the mid-19th century on, reformers worked to create specialized children's institutions as alternatives to adult prisons and jails, incorporating theories of crime that emphasized environmental rather than innate characteristics of the individual and that stressed rehabilitation. Child advocates secured the passage of California's first juvenile court law in 1903. During the next decade, substantial effort went into implementing a uniform juvenile code among California counties. To accomplish this, proponents left wide areas for differences in legal interpretation, launching the tradition of divergent local practices reflected in current arrangements.

Through the 1920s, the juvenile justice system was expanding and becoming more elaborate. The formal establishment of a juvenile court system was followed by the expansion of probation systems in most California counties. Despite the spread of this reform, wide variations persisted between counties in terms of detention practices, the qualifications of probation staff, and mechanisms for public oversight. In 1929, a new Department of Welfare was given the responsibility to bring greater consistency to juvenile court procedures, particularly with regard to out-of-home placements. These efforts met with the already strong tradition of county-based delivery of children's services (and social services generally; see Chapter 14). In these early decades of the century, the California system and the Los Angeles County juvenile programs in particular were hailed nationwide as progressive, model efforts.

A milestone in the establishment of the system was the creation of the California Youth Authority (CYA) in 1941. The CYA incorporated the legacy of Progressive era reforms in juvenile justice, emphasizing differentiated children's institutions and broad judicial discretion. Its establishment enhanced the state's reputation as a pioneer in the field of juvenile justice. The CYA had a broad mandate to establish standards for probation and for the operation of county juvenile facilities, as well as to provide research, management studies, and technical assistance to the counties for local juvenile corrections programs. The CYA took over administration of the state training schools after scandals at these sites, thus beginning its contemporary facility-based emphasis.

During the 1960s and early 1970s, the CYA received national attention for the quality of its research and for several highly regarded research and demonstration efforts. CYA directors established model programs as alternatives to incarceration, and promoted the value of delinquency prevention and child advocacy. In addition, the state actively explored such alternatives as diversion and deinstitutionalization, becoming "a virtual laboratory for new programs designed to avoid the costly and unproductive incarceration of troubled youth."[15] Despite these accomplishments, the CYA made little progress in promoting greater uniformity in county juvenile justice practices. If anything, juvenile justice practices grew even more localized.

New state and federal roles in children's services during the 1930s and 1940s had introduced pressures for standardization across the counties, as well as new political and organizational pressures. During the early 1950s, critics continued to focus on the disparities between counties with respect to informal police handling of cases, detention practices, and the protection of children's legal rights.

In 1957, a gubernatorial commission proposed a far-reaching reformulation of California's juvenile laws that emphasized vastly expanded due-process rights for juveniles, more uniformity in juvenile court procedures, and limitations on judicial discretion. In the early 1960s many of these principles narrowing judicial discretion were enacted in a recodified juvenile court law, anticipating constitutional requirements for due process for minors later set forth by the United States Supreme Court. This ideology and practice of discretionary power has been a basic component of juvenile justice systems since their inception around the turn of the century. The Progressive vision was that such discretion would enable rehabilitative treatment appropriate to the individual youth; in the 1960s, youth advocates argued that the de facto effect was to exempt children and youth from various due-process safeguards. Supreme Court decisions such as *In re Gault and* other holdings explicitly reaffirmed and extended such constitutional provisions for juveniles.

A comprehensive Juvenile Justice Reform Act (AB 3121) went into effect in 1977. This legislation mandated two major reforms: (1) more severe sanctions and possible transferral to adult court for older youth charged with certain felony law violations, and (2) the encouragement of the diversion of status offenders from the system. Diversion meant transfer to various community-based programs, outside the established juvenile system; the change further stipulated that a status offender could not become a law violator solely because the juvenile failed to obey an order of the court. A major effect of these changes was to reduce status offender referrals to probation.

Since the late 1970s, the legislature has made only minor revisions of the juvenile code consistent with the "get tough" rhetoric of the times, most recently amending the purpose clauses of the code to reflect protection of community restitution, rather than rehabilitation. A significant attempt to revise the entire juvenile code foundered amid inadequate resources and partisan disputes.

Another event with major impact on the current juvenile justice system was the passage of Proposition 13. The revenue limits produced severe fiscal strains on the county-financed system of juvenile services, and many services were curtailed or scaled back. Especially hard hit were "front-end" diversion and prevention efforts and special juvenile bureaus and diversion programs within police agencies. The situation worsened with the 1980 demise of the Law Enforcement Assistance Act (LEAA), a federal program that had funded many prevention and diversion programs. At the local level, county agencies and community-based organizations competed for increasingly scarce public funds.[16]

In addition, the federal role has been transformed in the last decade, after its substantive origins in 1974.[17] The perspective of the current administration emphasizes more stringent law enforcement and longer sentences aimed at juvenile law violators and miscreant youth. These policy initiatives come at a time when elected public officials and juvenile justice professionals in nearly thirty states, particularly in the west and south, are reexamining their juvenile crime control policies and strategies. The preferred approaches "[minimize] reliance on incarceration and [expand] the use of community-based programs."[18]

The shifts in the juvenile corrections system place additional burdens on other aspects of children's services. Concurrent but uncoordinated reforms generate further tensions and complexities that ripple through the de facto children's services system (see Chapter 13).

Youths in Formal Contact with the Juvenile Justice System

The majority of children and youth in California have almost no formal contact with law enforcement agencies or the juvenile justice system. Contact varies substantially, however, by such characteristics as age, gender, race and ethnicity, socioeconomic status, family conditions, and urban residence status. Older youth, boys, members of certain racial and ethnic minorities, materially disadvantaged youth, and youth living in cities and more urbanized counties are all more likely to have some formal encounter[19] with law enforcement agencies and to enter the juvenile justice system. Substantial variations exist by county as well, which may reflect county variations in the structure and practice of juvenile justice, as well as differences in county youth populations.

Juveniles come to the attention of the system most commonly through contacts with law enforcment agencies and to a lesser extent through referrals from schools, families, and other sources. Young people may be formally charged under two broad categories: criminal activities (either felony or misdemeanor) or status offenses. Major revisions to the juvenile code that took effect in 1977 effectively "decriminalized" status offenses, so we distinguish between such activities and criminal behavior.

No systematic or complete data on the incidence of juvenile delinquency are available. For practical reasons, much misbehavior, even of a criminal nature, goes undetected or is not reported. Beyond that, delinquent behaviors are necessarily defined by the law. The Code provides formal definitions of delinquent tendencies and behaviors.[20] Although there is public and professional consensus that delinquent behavior is present among all classes of children and youth, particular definitions of delinquency, and their implementation, have differed over time and across political jurisdictions. In addition to the formal definitions, the discretion exercised by law enforcement agencies and individuals (police officers and others) in deciding which specific individuals should be entered into the system, and for what behaviors, further contributes to variation in practice. Thus, even apart from complex definitional issues, the numbers of delinquents and delinquencies will vary as statutory definitions change. As one long-time student of delinquency observed, "delinquency has little specific behavioral content either in law or in fact" and "the juvenile delinquent is a person who has been adjudicated as such by a court of proper jurisdiction."

The diversity in legal definitions of delinquency, inaccuracies in counting, and the exercise of law enforcement and other professional discretion all contribute to the problems of reporting a "true" incidence of delinquency. Consequently, descriptions of the scope and variety of delinquency rely on various proxy measures. Here, we use arrest data. Arrest data provide one measure of the scope of juvenile crime and tell us about formal contacts among youth, law enforcement agencies, and the juvenile justice system. Available data over time about youth arrested,[21] their alleged crimes, and the disposition of their cases provide a perspective on aspects of juvenile criminal activity but also raise questions. These data are problematic in certain ways,[22] but they provide one of the best indicators of trends over time.

Contrary to popular beliefs, fewer youth had formal contact with the legal system, and juvenile arrests actually declined, through much of the 1980s. Arrests have increased slightly in recent years, but are at levels still well below those of the 1970s. There has been some change in the distribution of juvenile arrests across crime categories, although data limitations make it difficult to ascertain whether this reflects changes in criminal activity among juveniles, changes by law enforcement agencies in reporting crimes (for example, emphasizing certain crime categories as in the recent focus on drug-related activities), or capability (for example, improvements in training or technologies).

Trends in Delinquency

Contrary to a widespread misconception, overall arrests (and rates) among juveniles in California has declined for over a decade. Although juveniles do account for a disproportionate share of arrests, particularly for some property crimes, the general trends show declines. In general, youth crime tends to be concentrated in property crimes. The most dramatic trends in recent years, however, have been rapid increases in the rates of felony narcotics crimes, though these still comprise a very small proportion of all juvenile crime; moreover, it is unclear whether the upsurge in rates indicates real increases in this activity or heightened public concern and more aggressive law enforcement efforts to combat adolescent drug use.

Moreover, most juvenile crime is concentrated in the 10- to 17-year-old group, a population that has been declining in absolute and relative size for a decade. Demographic projections suggest this decline in size will continue through the early 1990s. Absolute levels of juvenile arrests tend to parallel the size of the youth population (defined as ages 10–17). Juvenile arrests increased from 1960 to 1975 (the peak year nationally for juvenile arrests) as the youth population grew. Between 1975 and 1985, the absolute number of arrests among juveniles declined, as did the overall size of the youth population. Also, trends over the ten-year period show declines when juvenile arrest counts are converted to rates per 100,000 juveniles in order to control for changing population size. Population data project that the youth population will again increase over the next ten years, suggesting the possibility of increase in the levels of juvenile crime.

Between 1975 and 1985, both felony and misdemeanor arrests among juveniles declined in absolute terms. Definitional changes in the law may account for some of the decline from 1975 to 1980, although the decreases from 1980 to 1985 represent reliable changes.[23] Of note is the reversal of this long-term downward trend in 1985 and 1986. Juveniles do account for a greater proportion of arrests than their share of the general population would predict. In 1985, juveniles accounted for 17.8 percent of all felony arrests and 10.3 percent of all misdemeanor arrests in California, still down substantially from five and ten years before. Status offense arrests continue to decline, but that may reflect policy decisions at the local law enforcement jurisdiction level rather than youth behavior. Without recourse to sanctions (such as detention), many police departments have substantially reduced their contact with truants and runaways.

Recent Statistical Trends in Arrests

With these general trends as background, subcategories of arrest data provide a more detailed picture of the types of activities for which juveniles enter the juvenile justice system. Table 11-3 shows the breakdown of felonies and misdemeanors, respectively. The data in this table tell (1) the composition of juvenile arrests; that is, what categories of crimes account for what proportion of total juvenile arrests; and (2) juvenile arrests as a proportion of all arrests (juvenile and adult) in each category.

Felonies. As Table 11-3 indicates, property crimes accounted for the majority (62.4 percent) of juvenile felony arrests in 1985. Juveniles accounted for 26 percent of all property-related felony

TABLE 11-2 California Juvenile Arrest Rates, 1975–1985

	Arrest Rates			Percent Change		
Arrest Category	1975	1980	1985	1975–85	1980–85	1984–85
Felony	4,031.8	3,203.0	2,576.8	–36.1	–19.6	+7.2
Misdemeanor	4,950.4	5,090.3	4,614.6	–6.8	–9.3	+4.9
Status Offense	2,716.5	999.8	903.3	–66.8	–9.7	–2.9
Total	11,698.7	9,293.1	8,094.7	–30.8	–12.8	+4.0

Note: Rate per 100,000 juveniles age 10–17 in the general population.

SOURCE: Bureau of Criminal Statistics and Special Services, California Department of Justice.

arrests, but the proportions varied across specific crime categories. Violent crimes amounted to about one-sixth (16.9 percent) of all juvenile felony arrests in 1985; cases of aggravated assault and robbery accounted for nearly all of these. Juvenile arrests were 17.8 percent of all violent crime arrests, but 21.4 percent of robberies. The remaining juvenile arrests were for drug law violations. Juveniles accounted for only 8.3 percent of all felony drug arrests, but 14.1 percent of arrests for marijuana.

Another way to examine these juvenile arrest statistics is to consider the incidence of arrests for varied categories of crimes and to compare the incidence among juveniles with that among adults. One measure of incidence is the arrest rate, calculated at arrests per 100,000 of the relevant population. Table 11-4 shows felony arrest rates for both juveniles and adults. Overall, the juvenile arrest rate is about 45 percent higher than the adult arrest rate; that is, compared to the adult population, nearly half again as many individuals in the juvenile population will be arrested. This proportion varies substantially among specific crime categories.

Recent trend data on incidence shows that the juvenile felony arrest rate overall declined by nearly 20 percent between 1980 and 1985, while the adult rate rose by about 12 percent. The exceptions to this decline in juvenile arrest rates were in felony drug arrests, which rose by about 30 percent, pushed up by substantial increases in narcotics arrests (163 percent). Beginning in 1985, however, overall juvenile felony arrest rates turned up slightly, paced by increased drug arrest rates (21.6 percent), especially for narcotics (70.2 percent).

TABLE 11-3 California Juvenile Felony Arrests Reported, 1985

	Number of Arrests	Percentage of Juvenile Arrests	Percentage of Total Arrests
Violent Crimes	12,421	16.9%	17.8%
Homicide	236	*1.9*	*7.6*
Rape	481	*3.9*	*11.4*
Robbery	5,180	*41.7*	*21.4*
Assault	6,366	*51.3*	*14.1*
Kidnapping	158	*1.3*	*7.0*
Property Crimes	45,899	62.4	26.0
Burglary	25,976	*56.6*	*33.0*
Theft	10,416	*22.7*	*18.6*
Motor vehicle	7,634	*16.6*	*28.2*
Forgery	858	*1.9*	*6.6*
Arson	1,015	*2.2*	*44.7*
Drug Law Violations	8,977	12.2	8.3
Narcotics	3,468	*38.6*	*6.3*
Marijuana	3,398	*37.9*	*14.1*
Dangerous drugs	2,033	*22.7*	*7.2*
Other	78	*0.9*	*6.2*
Total	73,521		17.8

Note: Numbers in italics are percentages within categories.

Misdemeanors. As Table 11-5 indicates, juveniles accounted for only about 10 percent of all misdemeanor arrests in California in 1985, but about one-third of all petty theft arrests and nearly 20 percent of all assault and battery arrests. Juvenile arrests for alcohol-related offenses are a small fraction of all juvenile misdemeanor arrests, and an even smaller fraction of alcohol-related arrests overall.

Paralleling felony arrest trends, the juvenile arrest rate for misdemeanors declined overall by nearly 10 percent between 1980 and 1985. Nearly all subcategories registered declines, with the exceptions of drug violations (an increase of 27.3 percent) and assault and battery (an increase of 2.7 percent).

TABLE 11-4 California Juvenile and Adult Felony Arrest Rates and Trends, 1980–1985

	Arrest Rate per 100,000 (1985)		Percent Change 1980–1985		Percent Change 1984–1985	
Arrest Category	Juveniles	Adults	Juveniles	Adults	Juveniles	Adults
Violent Crimes	435.3	346.3	–23.1	–12.5	5.5	1.3
Homicide	8.3	15.0	–43.2	– 6.3	–22.4	–13.8
Rape	16.9	19.4	–23.5	–12.2	–12.9	– 4.0
Robbery	181.5	99.3	–25.0	–10.9	+10.5	+ 2.0
Assault	223.1	201.5	–19.9	–13.6	+ 5.1	+ 2.7
Kidnapping	5.5	11.0	–36.0	–15.6	–11.3	+ 1.9
Property Crimes	1,608.7	682.0	–25.0	+ 4.6	+ 8.7	+ 5.4
Burglary	910.4	274.2	–24.8	–13.6	+ 3.4	+ 1.5
Theft	365.1	236.9	–27.1	+14.8	+10.1	+ 7.5
Motor vehicle	267.6	101.2	–26.5	– 4.8	+29.7	+11.2
Forgery	30.1	63.1	–12.0	+ 4.0	+ 5.2	+ 5.3
Arson	35.6	6.5	+ 3.8	+ 4.8	+ 7.9	+10.2
Drug Law Violations	314.6	519.5	+28.9	+56.3	+21.6	+14.5
Narcotics	121.5	269.2	+163.0	+134.3	+70.2	+25.7
Marijuana	119.1	108.2	–14.7	+15.5	+ 2.7	+13.4
Dangerous drugs	71.3	136.0	+32.0	+ 6.3	+19.3	– 0.8
Other	2.7	6.1	–35.7	–37.1	–35.7	–15.3
All Other	218.1	223.7	–12.2	+10.2	–13.1	– 2.5
Total	2,576.8	1,771.6	–19.6	+11.9	+ 7.2	+ 5.9

SOURCE: Bureau of Criminal Statistics and Special Services, California Department of Justice.

Characteristics of Youth Arrested, 1985. Table 11-6 provides a more detailed picture of the sociodemographic characteristics of juveniles arrested.

Gender. In 1985, boys accounted for 77 percent of all juvenile arrests, and also for the greatest proportion of arrests across each major category or type of offense. Particularly striking was their 89

TABLE 11-5 California Juvenile and Adult Misdemeanor Arrest Rates and Trends, 1980–1985

Arrest Category	1985 Arrests Number	1985 Arrests Percent	1985 Percent of Total Arrests	Juvenile Arrest Rate 1985ª	Adult Arrest Rate 1985	Juvenile Percent Change 1980–1985	Adult Percent Change 1980–1985	Juvenile Percent Change 1984–1985	Adult Percent Change 1984–1985
Assault and battery	12,273	9.3%	19.5%	430.1	264.3	+2.7%	+6.4	+4.9	+4.2
Petty theft	39,080	29.7	31.3	1,369.1	446.8	–9.1	+14.2	+4.4	+5.3
Drug law violations	15,583	11.8	12.2	546.2	585.6	+27.3	+92.2	+0.6	+8.9
Drunk	6,589	5.0	3.3	230.9	1,014.2	–40.8	–23.6	–4.7	–9.0
DUI	3,801	2.9	1.1	133.3	1,753.5	–20.7	+22.0	–2.3	–3.0
All other	54,340	41.3	13.0	1,904.5	1,898.7	–12.5	+12.3	+8.5	–0.7
Total	131,667		10.3	4,614.6	5,963.1	–9.3	+5.0	+4.9	–1.5

ª Per 100,000 same age (ages 10–17).

TABLE 11-6 Personal Characteristics of California Juvenile Offenders, 1985

	Sex		Age			Race			
Arrest Category	Male	Female	13 and Under	14–15	16–17	White	Black	Hispanic	Other
Felony	89%	11%	16%	35%	49%	43%	25%	28%	4%
Misdemeanor	77	23	18	33	49	56	14	25	5
Status offense	55	45	16	44	40	65	12	19	4
Total	70	21	17	35	48	53	17	26	4

percent share of felony arrests. The proportion of arrests accounted for by girls is inversely related to the severity of the offense—a relatively higher proportion of those arrested for status offenses than for other types of offenses were girls (45 percent). Although the girls' share of juvenile felony arrests has been fairly constant since 1975, they have steadily increased their share of misdemeanor arrests, from 14 percent in 1975 to 18 percent in 1980 to 23 percent in 1985.

Age. Young people 16 and 17 years old accounted for nearly one-half of all juvenile arrests, followed by 14- and 15-year-olds with about one-third, and those 13 years and under, 17 percent. The distribution of arrests across age groupings is similar for both felonies and misdemeanors, with the exception of status offenses, where 14- and 15-year-olds have the largest proportion of arrests (44 percent), followed by older youth (40 percent).

Race and Ethnicity.[24] Most juvenile arrests (53 percent) are of non-Hispanic white youth, followed by Hispanics (28 percent) and blacks (25 percent). This overall percentage of arrests accounted for by each group is roughly proportional to their share of the total youth population of the state. Within each arrest category, non-Hispanic whites have the largest proportional share, though their share is inversely related to the severity of the offense—that is, relatively higher proportions of those arrested for relatively less serious crimes were non-Hispanic whites—felonies, 43 percent; misdemeanors, 56 percent; and status offenses, 65 percent. Hispanics are the second largest group in each arrest category, and for both Hispanics and blacks, their share increases with the severity of the offense. Non-Hispanic white youth are much more likely to be arrested for status offenses than are blacks or Hispanics—whether this represents actual differences in behavior or bias on the part of law enforcement is at issue.

These numbers describe the racial and ethnic composition of arrests within each category. Another way to examine these figures is to consider the distribution across arrest categories for each group (Table 11-7). Misdemeanor is the most common arrest category among non-Hispanic whites (60 percent), Hispanics (57 percent), and "others" (61 percent). Felonies are the next most common category for these groups, although black youth are equally likely to be arrested for felonies and misdemeanors (46 percent). Status offenses comprise the smallest proportion of arrests for each group, though non-Hispanic white youth are more likely to be arrested for status offenses than are blacks or Hispanics.

These data portray one perspective on who juvenile offenders are and with what sorts of crimes they are involved. In addition to the explicit technical limitations of the data just described, these data describe juveniles whose activities result in arrest. Substantial research has examined the processes and factors involved in police decisions regarding the forms of contact with juveniles potentially involved in infractions—arrests or other informal interventions such as warnings.[25]

TABLE 11-7 Types of Arrests Experienced by California Juveniles of Different Races/Ethnicities, 1985

	Percentage of Arrests Within each Group			
	Felony	Misdemeanor	Status Offense	Total Number of Arrests
White	26%	60%	14%	122,440
Black	46	46	8	39,085
Hispanic	35	57	8	58,808
Other	31	61	8	10,628

After Arrest: Disposition Alternatives and Practices Once in the System

Once a juvenile is arrested, he or she enters a system with multiple decision points. Figure 11-1 is a summary diagram of the California juvenile justice system that shows the sequence of formal decision points and possible dispositions for an individual's case. At each point, the case may be dismissed, transferred to another public or private agency, adjudicated to some form of probation, or referred on to the next step. Substantial discretion is available all through the system, especially in the early stages. Law enforcement agencies tend to have first contact with possible juvenile offenders and make an initial decision about further action; available disposition options range from releasing the person with a warning to referral to a county probation department. Law enforcement agencies (or schools, parents, and others) initiate the process by a first referral to a county probation department. Even this first contact and decision to refer to the probation department includes a considerable amount of discretion. Research suggests that wide variations exist in whether any given young person will be released to family. Among counties and among individual law enforcement professionals, variation exists at the point of first contact with law enforcement agencies or others to even refer a youth to the county probation department. Probation departments have a number of dispositional alternatives: a case may be closed or transferred, a juvenile may be placed on informal probation, or a petition may be sought for a juvenile court hearing. The juvenile court places most new petitioned cases under probation department supervision (70 percent formal probation and 4.8 percent nonward probation in 1986), closes some, and detains others.[26]

Dispositions of Juvenile Arrests and Referrals

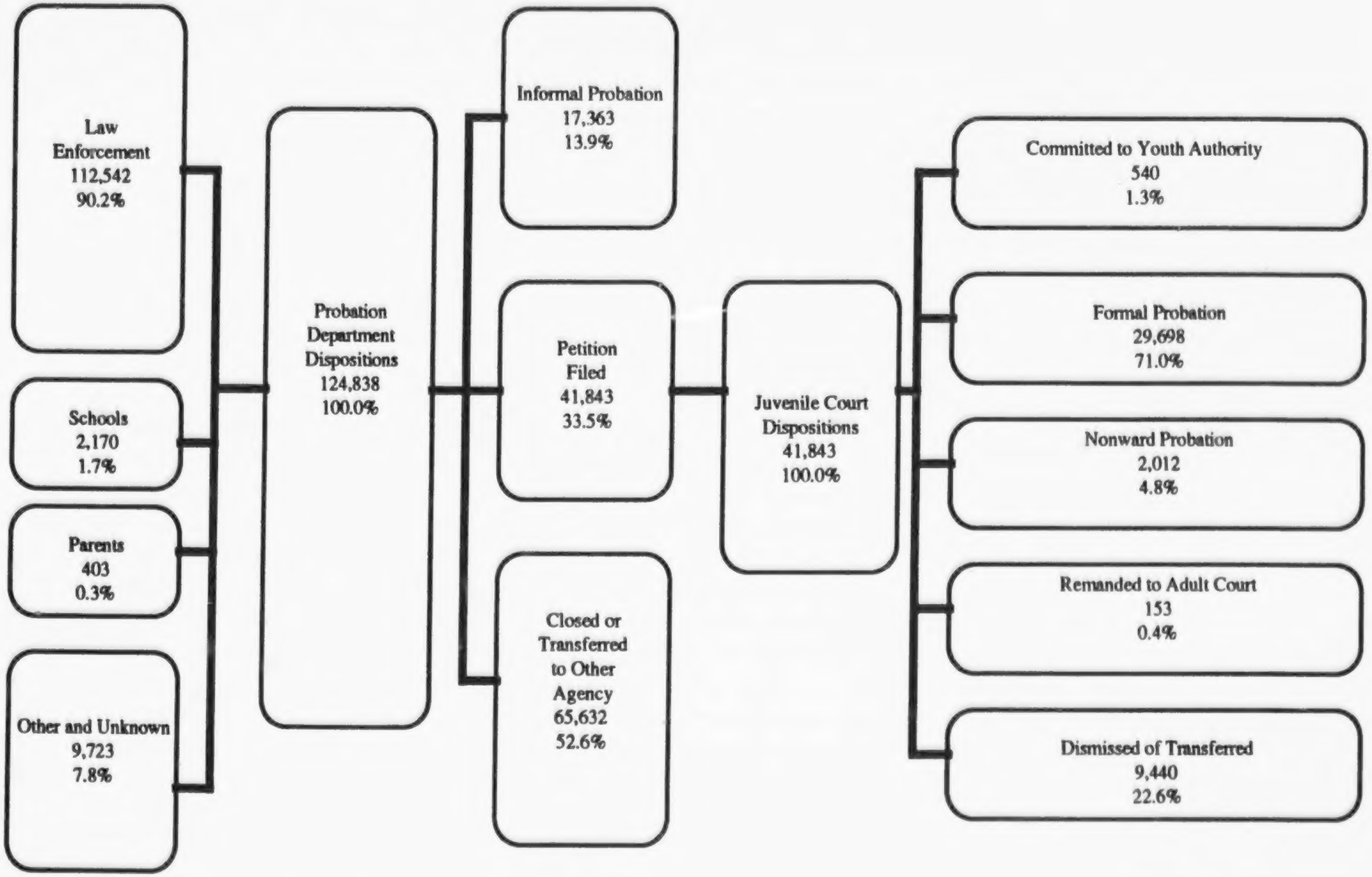
Juvenile arrests were up somewhat in 1986, continuing an upturn that began in 1983 after nearly a decade of declines. About two-thirds of the referrals resulted in further formal action by the probation department. Of these, about one-third were brought into the juvenile court. Over 70 percent of these cases resulted in formal probation and hence possible confinement in county camps. The trends since the early 1980s are for increases in the proportion of cases that result in probation department actions, petitions filed in the juvenile court, and dispositions to formal probation—essentially, a system relying more on formal adjudication and confinements for a larger proportion of cases.

Intake. Juvenile arrests have increased in both number and rates since 1983, after nearly a decade of declines. Guided by folk knowledge that, for most juveniles, their first or second arrest will be their last, many police and probation officers at the "front end" of the juvenile justice system rely on informal disposition options. Of 235,880 juvenile arrests in 1986, law enforcement agencies closed or handled by informal counseling or referral to diversion programs more than 32 percent. It is not unusual in some jurisdictions for a juvenile to accumulate a substantial arrest history before he or she ever comes before a judge—a function of both rehabilitative ideologies and system overload. Most juvenile offenses are relatively minor and receive commensurate attention; given the volume of cases, lack of facilities, and choice between detention and release for a minor offense, release—often back to the parental home—often seems the most viable alternative.

The remaining 67 percent were referred to probation departments, the initial intake site for the juvenile system.[27] By offense level, the referral to probation was 78.4 percent for felonies, 65.5 percent for misdemeanors, and 44.3 percent for status offenses. Trends since the early 1980s show an increase in the proportion of arrests referred to probation departments for further disposition and a decrease in that handled within the department.[28]

During this 1980–1985 period, the number of new juvenile court petitions filed was also lower, albeit this decline was not as

FIGURE 11-1 Dispositions of New Referrals, 1986


Law Enforcement
112,542
90.2%
Schools
2,170
1.7%
Parents
403
0.3%
Other and Unknown
9,723
7.8%
Probation Department Dispositions
124,838
100.0%
Informal Probation
17,363
13.9%
Petition Filed
41,843
33.5%
Closed or Transferred to Other Agency
65,632
52.6%
Juvenile Court Dispositions
41,843
100.0%
Committed to Youth Authority
540
1.3%
Formal Probation
29,698
71.0%
Nonward Probation
2,012
4.8%
Remanded to Adult Court
153
0.4%
Dismissed of Transferred
9,440
22.6%

SOURCE: *Crime and Delinquency in California, 1986*. Bureau of Criminal Statistics and Special Services.

great as the drop in juvenile arrests. This decline suggests that a higher proportion of juvenile arrests were being formally adjudicated, with fewer cases handled informally or referred to other community agencies.

In 1986, of 124,838[29] new referral[30] dispositions, county probation departments closed or transferred 52.6 percent (for lack of evidence or because first-time offenders were not likely to repeat), set terms of informal probation for 13.9 percent, and filed petitions in the juvenile court on 33.5 percent (that is, a 602 WIC delinquency petition was filed in the Juvenile Court, which means that an intake officer decided that existing community or family resources were insufficient and that the case must be resolved by formal adjudication).[31] Although the net change in petitions filed since the early 1980s shows a slight decline, petitions filed rose to nearly 38 percent in 1983 and have declined since then.

Table 11-8 sets out data on the disposition of these new referrals (almost 125,000 in 1986) statewide and for the five counties with the highest number of referrals. The filing rates in 1985 for the five counties with the largest number of probation referrals shows substantial variation across jurisdictions. A full 60 percent of referrals resulted in petitions in Los Angeles County, more than twice as many as in San Diego (28 percent) or in San Bernardino (19 percent) Counties. Similarly, while almost two-thirds of new referrals were closed by probation in San Bernardino and Alameda Counties, only 27 percent were closed in Los Angeles County. Orange County used informal probation for 19 percent of new referrals compared to only 3 percent in Alameda County.

Juvenile Court Dispositions. Of the new petitions filed in juvenile court, 22.9 percent of the cases were dismissed, transferred, or remanded to adult court; 4.8 percent were placed on nonward probation; 71 percent were placed on formal probation; and 1.3 percent were committed to the California Youth Authority. Trends from the early 1980s were for net but uneven decreases in cases dismissed, transferred, or remanded; increases in cases placed on formal probation; and a very slight net decrease in the proportion committed to the Youth Authority (although there have been slight increases since 1984).

TABLE 11-8 Probation Disposition of Juvenile New Referrals, Statewide and in the Five Counties with the Largest Number of Referrals, 1985

Disposition	Arrests Statewide		Percentage of Arrests Within each County				
	Number	Percent	Los Angeles	Orange	San Diego	San Bernardino	Alameda
Closed	58,249	48%	27%	44%	56%	65%	63%
Transferred	2,773	2	—	—	—	1	—
Informal Probation	17,654	15	13	19	16	15	3
Petition filed	41,792	35	60	37	28	19	34
Total	120,468						

SOURCE: Bureau of Criminal Statistics and Special Services, 1985 Criminal Justice Profile, California Department of Justice.

Juveniles are supervised by county probation departments after placement on informal, nonward, or formal probation. Of 61,644 juveniles on probation at the end of 1986, 87.5 percent were on formal probation (which carries open-ended tenure); the remaining 12.5 percent were on either informal or nonward probation, both of which have six-month maximums. At the end of 1985, there were 78,812 juveniles on probation in California, 41 percent of them in Los Angeles County.

Juvenile Court Proceedings. In addition, the juvenile court handles cases of neglected, abused, and dependent children. Juvenile court practices have come increasingly to resemble criminal court (adult) proceedings, although the guiding rhetoric is still treatment and rehabilitation. The legal justification for different placements is that the juvenile is in need of the treatment programs offered in these varied settings.[33]

From 1980 to 1985, the statistics on correctional populations showed significant increases. The number of juveniles on probation rose by 66 percent; the number in county detention centers, camps, and ranches grew by 24 percent; and the juvenile population of the California Youth Authority grew by 66 percent. In all, 85,941 Californians under age 18 were being controlled by various state and local correctional agencies, constituting 3 percent of the state's youth population. The proportion of California youth under correctional supervision increased by 50 percent between 1980 and 1985.

These data portray a system that is becoming more formal, more restrictive, and more oriented toward punishment. In addition, probation caseloads have increased to levels that make adequate supervision unrealistic, and county and state facilities face chronic and severe overcrowding.

Probation. Most juvenile courts treat offenders with a limited prior arrest record fairly leniently, usually sending them home on probation. The sentence sometimes includes additional weekend incarceration, or a work service or restitution requirement. In 1985, about 74 percent of new 602 WIC wards were put on probation in their own homes or the homes of relatives. This action is based on the dual assumption that the minor's criminal activity is not likely to escalate and that institutional settings may do more harm than good.

In the current fiscal climate, little in the way of community programming falls between these two options (recall that these would be county-level programs). In recent years the counties have not developed a range of options around alternative community programs. Statutory and fiscal incentives encouraging the development of such programs disappeared about ten years ago.

When the minor's home environment is questionable, or when intensive treatment is required, "suitable placement" in a foster home or group home is another alternative. An additional 6 percent of new 602 WIC wards were sent to foster or group homes.

Juvenile Halls and County Camps. The next level of restrictiveness is confinement in a county facility, either a juvenile hall, county camp, or ranch. In addition, some counties have begun using placements in private treatment programs (for example, San Diego County placements in VisionQuest).

County-operated detention facilities for juveniles include both secure facilities such as juvenile halls, camps, schools, and ranches, as well as nonsecure facilities such as shelter care and crisis resolution homes. In 1986, approximately 8,598 juveniles were in county-operated facilities.

In 1985, California's forty-seven juvenile halls held 5,332 beds. These had an average daily occupancy rate of over 90 percent (4,817), up nearly one-third from 1979. Juvenile hall placements have typically been used for individuals while awaiting trial or an opening in a county camp, CYA, or private facility. Critics note that no effective or consistent detention criteria, such as type of offense, arrest history, and escape history, are in regular use. Increasingly, judges are sentencing offenders to juvenile hall as part of their probation, both as a punishment and as a deterrent to future criminal behavior. This trend puts new and further stresses on the juvenile halls as they become employed as de facto prisons, housing an ever-increasing mix of juveniles, some for increasing periods of time.

Juvenile halls in the eleven largest counties in the state are chronically overcrowded. In Los Angeles County, the capacity of the three juvenile halls is about 1,450, yet the daily inmate population reached between 1,800 and 2,000 juveniles several times in 1986. There were 29,450 total admissions in 1985 alone. Overcrowding and other stressful and dangerous conditions in the juvenile halls of Los Angeles and San Francisco Counties have been the subject of a federal investigation in the past year, as well as the topic of innumerable official, newspaper, and private reports.

California counties maintained fifty-three camps and ranches, with a capacity of 4,018 and an average daily population of 3,523 in 1985. About 6,600 wards were processed through them in the course of a year, with average length of stay about six months. Since 1979, the population served by these facilities has increased by 36 percent. In addition to educational and counseling programs, camps typically offer vocational programs (such as forestry) and physical recreation activities.[33] The county camps (including camps, ranches, and schools) occupy a particular niche in the ecology of secure detention facilities in the state. Moreover, they provide a more variable set of restrictive environments than CYA state institutions. Moreover, probation camps have become increasingly important in recent years as a result of the increasing overcrowding within state institutions. In light of the large increases in institutional population and severe overcrowding in state institutions, these facilities are routinely cited as a resource that prevents even worse overcrowding in the state facilities. They are the "last local stop" and perhaps last local opportunity for many probationers; without these facilities, overcrowding within such institutions—specifically California Youth Authority facilities—would probably be greater still. The contention, though, is that young people whose offenses would formerly have brought them into the state facility may be in county sites.

Data from a major descriptive and evaluative report on California's juvenile probation camps, ranches, and schools (together called *camps*)[34] provide information on the youth population in the camps, as well as program, administration, and camp effectiveness.[35] The camps currently admit over 14,000 youth per year (15,000 in the early 1980s), and have an average daily population of more than 3,400. This study surveyed all 3,774 youth in the fifty-three camps, ranches, and schools operated by twenty-three counties in mid-1984.

California Youth Authority. Less than 2 percent of youthful offenders were placed in the most restrictive component of the system—the California Youth Authority, the largest youth offender agency in the nation. It operates seventeen varied facilities (ten institutions, six conservation camps, and one prerelease site), most in rural areas of the state, ranging from a 35-bed prerelease facility in Silverlake to the 1,200 bed, prison-like Youth Training School in Chino. The official capacity is 5,480, but these facilities housed more than 8,000 juveniles in 1985, with a projected need for 9,015 beds by the year 1990. Individual CYA facilities are currently running at between 115 percent and 167 percent of designed capacity. Overcrowding at the Youth Authority has been the subject of a private research study[36] and legislative hearings. Both these sources describe conditions and consequences ranging from simply inadequate to nightmarish. "It is generally acknowledged that overcrowding is a major cause of warehousing, disciplinary problems, tensions among staff members, low staff morale, and violence among juveniles and between juveniles and staff".[37] New commitments have been relatively stable for the last several years, so the cause of the overcrowding is not an unforeseen upsurge in new inmates. Two factors do appear to have contributed to the overcrowding. Recent legislative changes permit the continued housing of 16- to 20-year-old adult offenders until they are 25 years old ("M cases"), affecting over 2,000 youth in 1984 and 1985. In addition, the Youthful Offenders Parole Board made a conscious policy decision to extend the length of stay of CYA wards. It has increased from 12.7 months to 17.4 months since 1975 (18.1 in 1981, 19.0 in 1985), and recent policy decisions (allowing incremental time for disciplinary reasons and parole violations) may add an estimated 5.7 additional months during the next five years,[38] resulting in a two-year average length of stay by 1990.

The Youthful Offender Parole Board (YOPB) is the paroling authority for young offenders committed to the CYA. California is one of the few states where the parole board is a centralized agency separate from the Youth Authority. Modifications to the parole guidelines that extend the base confinement time for certain types of inmates are "slated for implementation in the near future. . . these revisions will increase the amount of time certain offenders spend incarcerated prior to being. . . considered for parole."[39] The YOPB is acting from a position that "public protection is enhanced by increased confinement time."[40] Three factors contribute to the overcrowding: revised policies of the YOPB that extend lengths of stay, the provisions of SB 821 removing children from adult jails, and the overcrowding itself (which generates a cycle of add-ons to sentencing as a result of inmate infractions).

The overcrowding comes at a time of a fundamental split over philosophies and practices within the juvenile justice field. At one extreme are such states as Massachusetts and Utah, which have come to be viewed as leaders in developing such programs as group homes, foster care, and other alternatives to incarceration. At the other extreme is California and some other western states that are tending toward incarceration. The problem expresses a painful debate about (1) the nature of juvenile justice in California and the nation and (2) whether incarceration is the best approach to young offenders. The issue has major implications at a time when demographic changes are expected to bring a growing number of youth into the so-called high-crime age groups of the population in the mid-1990s. Those who support the incarceration of young people say many young offenders are dangerous criminals who should be taken off the streets. Critics say incarceration simply creates hardened youth with a lifetime of crisis ahead.[41]

The more rehabilitative and more punitive philosophies of juvenile justice represent somewhat abstract poles in the debate. In policy and in practice, these goals are not incommensurable—political, organizational, and procedural arrangements are available that enable the safeguarding of the community while maximizing rehabilitative aspects of confinement. For example, there is widespread consensus that many young people are serious and violent offenders, requiring secure detention. At the same time, only a proportion of confined youth fit this profile, and mixed among them are substantial numbers of youth with less violent or aggravated histories who might be better and more economically diverted into other arrangements.

A recent study by the Commonweal Research Institute, a nonprofit research organization in Bolinas, California, describes widespread violence and gang activity throughout the Youth Authority's facilities. Critics say one reason California has such a devastating gang problem is that its juvenile justice system has become a breeding ground for young criminals in much the same way its prisons are for older criminals.

Confinement and Probation

Data on the characteristics and conditions of youth in the juvenile justice system are rudimentary and largely administratively driven. Some basic demographic and background data are available on youth. For CYA first-commitment youth, available information includes basic demographic data, detailed information on current offense and prior history, and some socioeconomic and family data. Hence, we can generate fairly systematic profiles of first-commitment youth to these institutions, their recent careers in the juvenile justice system, their family and neighborhood circumstances, and their schooling attainment, as well as how these characteristics have varied over recent years and decades. For county camp populations, a one-time census in 1984 provides the most complete (and current) data available on the characteristics of these youth, although changes may have occurred since then; in addition, comparisons to samples of the probation, juvenile hall, and CYA populations were performed at the same time, but these are mostly simple demographic data. No other systematic, current sources are available for characteristics of the probation or juvenile hall populations.

Conditions. None of these data sources provide indicators of the conditions of these young people, save for aggregate measures such as population in relation to capacity of the facility, descriptions of program, and the like. Recent private and public reports on overcrowding in state and county facilities provide further information about some of the conditions and their consequences; they are concerned with basic issues of personal security and survival in badly strained large-scale institutions. Information is difficult to find regarding access to educational opportunities and training programs, access to substantive rehabilitative activities, and the quality of life in the environments where a not insubstantial number of California youth may spend a year or more of their adolescence.

CYA reports emphasize and document the recent development of additional education and training programs in state facilities as a means to further structure everyday life in the institutions in order to minimize inmate violence stemming from overcrowding. In addition, 1984 data for county camps depict the program variations among these fifty-three facilities, both in content and staffing. Absent from these descriptive accounts are definitions of need, systematic diagnostic data, or criteria by which to assess existing program efforts. Indeed, that programs exist at all amid the constrained fiscal resources and the physical strains of the overcrowded conditions tends to elicit stoic defenses from juvenile corrections administrators and praise from concerned legislators and others. Official statements emphasize the development of alternative programming and maximal use of available facilities and staff. These include both enhanced educational and training programs, as well as new emphasis given to "security and crisis intervention counseling and coping and confronting young people [to] let them know there are consequences to their behavior." The emphasis of these commentaries is to point to the increasingly structured and programmed daily existence of youthful inmates as their response; these same commentaries minimize the substantive effects of overcrowding.

Other research systematically examines the effects of overcrowding on CYA facilities—including empirical studies that document the reduced incidence of violence when the number of inmates in a dormitory facility drops to 37, and more general reviews of the environmental conditions including crowding in CYA facilities.[42] At the time these studies were done, average numbers in a living unit were forty to forty-five inmates. A more recent study carried out by the Commonweal Foundation takes a more aggressive view of the situation. Conducted with the knowledge and cooperation of CYA administrators, it documents, through a series of case studies, the serious harms and violence that face many inmates forced to live in these conditions. It underscores reports of the pervasiveness of racial and ethnic minority gang cultures and gang-related violence in the institutions, that extends back into the community after release. During the series of visits that provided data for Lerner's "Bodily Harm" report, the number of inmates had risen to between fifty and fifty-five per living unit. By mid-1986, the director of the CYA testified that certain living units had up to seventy members.[43]

Private reports and public testimony by CYA officials concur that the reported levels of inmate against inmate violence have increased enormously: 13 percent of the disciplinary actions in CYA facilities was for "ward-on-ward assaults without weapons"– up from 400 incidents to over 1,200 incidents a year by 1985, a 300 percent increase. In recent testimony, CYA Director Rowland noted "a dramatic increase in fighting and young people assaulting other young people in the Youth Authority. . . most of it, we think, gang related."[44]

Conditions of Education and Other Social Services. Scant systematic evidence is available on issues that span the formal juvenile justice sector to connect with other policy sectors that affect the everyday lives of these children and youth. The education of youth in county and state facilities is a highly controversial area– critics raise questions about the educational program, particularly in short-term detention facilities, while voices more supportive of the juvenile justice professionals point to the overburdening of the system on all dimensions, such that physical safety, let alone learning opportunities, are compromised. For example, Price and Vitolo point out in a recent commentary that despite the current interest in school reform, "few proposals have addressed the status of minors in correctional institutions and its relationship to mainstream public education." They go on to note that in Los Angeles County alone "as many as 50,000 young people go through the juvenile court and correctional system annually," and suggest the havoc such experiences play in the schooling of youth who "[come] to the system with a scattered history of educational achievement."[45] They propose a "bill of educational rights" for incarcerated young people.

Educators and other social service professionals routinely describe high proportions of the youth confined in state and county facilities as candidates for a myriad of special services, though resources seldom provide these services. Such indicators as are available on these needs bear out the professional assessments. For example, most youth in the institutional population have had sporadic school attendance records and have tested at low skill or competency levels. Recent testimony by a representative of the educators working in detention facilities noted that a substantial proportion of inmates would qualify for IEPs under the provisions of PL 92-142, though such resources are unavailable.[46] Mental health professionals and others report similar conditions and situations. The relationships between mental health services and professionals and the juvenile justice sector are perennially problematic– characterized by differing philosophies, professional ideologies, practices, and resources, as well as often competing authority and jurisdiction. For example, diagnoses and treatment routines established by mental health professionals may be changed or accommodated to the procedures of a particular detention facility; in some cases, the lack of mental health services or the physical constraints of a facility preclude arrangements that would seem otherwise appropriate. Newspaper headlines and some more systematic reports note cases of injury and sometimes death, where competing organizational or professional jurisdictions contributed to the outcome.

Even more problematic, some children– not the perpetrators, but the victims of crime– end up in detention facilities because no other options are available. One issue here has to do with the variation in the cultures– norms, values, resources, and infrastructure– of the juvenile system across counties, such that youth with similar backgrounds brought in for similar offenses may receive substantially varying dispositions. Moreover, some counties maintain minimal juvenile facilities and routinely send juvenile offenders in a wide class of offenses on to the Youth Authority. Hence, children and youth of varying ages, whose infractions span an inordinately wide array of situations, find themselves together in the state facilities.

Characteristics. The vast majority of the California Youth Authority population are boys and young men, almost three-quarters of them from racial and ethnic minority groups. A generally increasing proportion of these youth are referred from the juvenile system, about 72 percent in 1987. Violent crimes remain the largest crime category of commitment (47 percent), but are a declining proportion of the total. Narcotics and other drug offenses, as commitment offenses, have increased extremely rapidly, up to nearly 10 percent from about 2 percent in 1980. Approximately 80 percent of the inmates are first commitments, a proportion that has been substantially the same throughout the 1980s.

Only a small percentage of new juvenile court commitments and subsequent commitments are to the California Youth Authority (413 and 1,996, respectively, in 1985). Among these young people, however, 86.7 percent had more than one prior conviction and 24.4 percent had five or more convictions. Approximately 66 percent had already served time in a county facility, and a similar percentage had a history of gang affiliation. Approximately 40 percent were committed for violent offenses against people.

The sociodemographic characteristics of CYA wards are also of note.[47] More than 70 percent came from neighborhoods characterized as "moderately or highly delinquent," and 92 percent came from homes with only one biological parent present. More than half (52 percent) had a parent or sibling with a criminal or delinquent record. As many as 85 percent had a history of substance abuse. Their average age was 18 years, yet their reading comprehension and arithmetic skills were at the seventh grade level. Fully one-third were functionally illiterate. More than 25 percent were severely emotionally disturbed and in need of psychological services. Racial and ethnic minorities were disproportionately represented in the 1985 CYA commitment group: 37.9 percent black, 31.7 percent Hispanic, and 27.5 percent non-Hispanic white. Commitment rates (per 100,000) for blacks are six times that for whites, and for Hispanics they are more than twice that for whites.

The profiles of these youth tell a story of now-familiar social pathologies. The vast research literature that has documented these correlations has also sought to determine causal relationships among and between such factors and broader social and economic conditions. The relationships between characteristics of the individual and delinquent status remain contested.[48]

CYA Plans

The CYA response has been to propose construction of 1,718 new institutional bed spaces at a capital outlay cost of between $122 million and $142 million.[49] Youth Authority plans call for 1,700 new beds over the next five years, in 100-unit facilities, with two totaling 600 units. Youth advocates and others have called into question this implicit state policy of relying on further expanded incarceration of juveniles. They point to federal statistics that indicate that on any given day as many as 430 per 100,000 of California juveniles are incarcerated, a rate *twice* the national average and two, three, and four times higher than rates of other large states. These advocates argue that before further expansion of juvenile corrections institutions takes place, literally building in a commitment to a strategy of even more incarcerations, policymakers should explore alternative directions.

The situation in California parallels the conditions in many of the states that have begun to dismantle the large-scale institutions. "The problems nationwide often begin with too many kids and too little space. 'Get tough' policies in many states have stiffened penalties and lengthened prison terms, putting still greater strain on already overburdened institutions and their staffs."[50]

Alternative Program Responses

Varied program alternatives do exist. There is no shortage of program ideas. However, there is a lack of convincing evidence for their effectiveness, with decreased recidivism as the criterion for success. Much of the research and evaluation data so far, however, have been flawed and inconclusive.[51] In the search for alternatives to an unsatisfactory status quo, many have argued for an extension of punishment and incarceration. This strategy is very costly– costs for holding one juvenile for one year in the Los Angeles County Juvenile Hall were $44,000 in 1984– and no clear evidence suggests that incarceration has a positive effect on reducing recidivism.

Other reforms include the development of a statewide risk assessment scale for juvenile offenders that might help standardize sentencing guidelines and serve as a criterion for evaluating sentencing policies of the parole board. Such an effort has also stimulated the development of smaller, community-based treatment alternatives, as in Massachusetts and Utah; legislative proposals to develop and field-test such a risk assessment scale have been vetoed by the governor.

In addition to public institutions, a number of private-sector contractors have begun providing services oriented to rehabilitation. These include innovative program models such as wilderness challenges and intensive tracking programs. These programs provide alternatives to the high fiscal and social costs of incarceration. Some are nonresidential and combine hard work with job-skill training and remedial education; others are based on Outward Bound and similar activities, building on adolescents' needs for physical challenge and risk and using intensive staff-ward interaction and teamwork to resocialize committed youth and to build their self-esteem. Yet another model emphasizes keeping juvenile offenders in the community, focusing on early intervention and prevention of further criminal activity.

Varied policy recommendations that include public- and private-sector program options have been made recently. Unquestionably, core law enforcement and probation functions cannot and should not be privatized. But in the search for effective treatment alternatives, the prudent use of privatization could inject elements of accountability and competition into a system where they are currently absent, although recent research challenges these claims of private efficiency and points out costs.[52] It could also help to stimulate some much-needed optimism among the general public about what can be accomplished with the population of juvenile offenders. To completely forfeit the goal of rehabilitation in juvenile corrections would deny justice both to young offenders and to the society in which they live.

Overview of Gang Activities and Recent Attention to Gangs

Recent media attention to youth gang activities has sharply focused public attention on the resurgence of gang activities, particularly the possible connections between urban drug economies, the involvement of increasingly younger children and youth, and apparently drug-related violence in several California cities and communities. Almost one hundred years ago, the then-eminent psychologist G. Stanley Hall claimed that "gang" instincts were a natural part of adolescent development. Since then, the media, police, and researchers have brought these issues periodically to the attention of the public. The current wave of concern with gangs emphasizes at least five components: (1) proliferation of gangs among various ethnic minority and recent immigrant groups, as well as among majority white youth (including "skinhead" offshoots from varied white supremacist movements); (2) violence associated with gang rivalries, including numerous deaths among both gang members and others, ranging from young children to the elderly;[53] (3) increased evidence of gang involvement in large-scale as well as "on the street" illegal drug activities; (4) territorial claims and counterclaims that have made many urban neighborhoods, parks, and recreational facilities dangerous places to be; and (5) appearance of gangs in many smaller communities[54] and their pervasiveness and power within California juvenile institutions.[55]

At recent federal hearings, past and current gang members, law enforcement officers, and social service officials described how gangs function as a sort of family for their members. "The gangs provide the youth housing, income, and support during stressful times."[56] Such perspectives have favored the development of gang intervention programs, rather than the perspective that the best way to deal with gangs is through stricter law enforcement and stronger sentences.

Thus, localities unused to dealing with gang problems have been forced to devise coping mechanisms. One option for communities is increased law enforcement. Other proposals aim at preventing youth involvement in gangs and violence through early intervention, including a broad range of social services. Many cities face the question of how to deal with current gang members who may not be best served by the criminal justice system.

Not all gang activity is negative, nor is all school disorder the product of gangs. Audrey James Schwartz cites 1982 data from the Los Angeles County Sheriff's Office that estimates gang membership at between 30,000 youth in 300 to 400 gangs.[57] Schwartz's survey of thirteen high schools in mostly Hispanic East Los Angeles suggests that 7 percent of the students were currently associated with a gang, and 12 percent said they previously had belonged to one. She concludes that gang membership peaks before tenth grade, which may be to say that young people who persist in gang involvement tend to leave school by the tenth grade, a situation corroborated by much anecdotal evidence among gang members. She also documents various school-based strategies for retaining order in the school setting, including the presence of guards, the practice of identifying and then transferring gang leaders, the keeping of discipline files on students, the prohibition on wearing identifying gang paraphernalia, and the positive roles school personnel can play in reducing gang tensions on the school site. Schwartz concludes that the gangs represented in her study:

> Differ from traditional Latino gangs in that they are less tightly structured, less controlling of their members, and less concerned with defense of neighborhood space. . . They differ from many Asian and black gangs in that they are not as involved with entrepreneurial criminal activities and less influenced by criminal gangs. . . And they differ from "stoner" gangs now emerging among young Latinos in that their values are not counter-cultural nor are they exclusively occupied with drugs and alcohol.[58]

Reports on the number of gangs and involved youth vary substantially, with estimates of up to 600 gangs and a combined membership of 70,000.

Runaway and Homeless Youth

Current estimates of the number of runaway and homeless children and youth in California vary. There is generally inadequate information on the number, types, characteristics, and locations of runaway and homeless youth; the data often vary with the perspective of the collecting agency or organization. Wide consensus exists among advocacy organizations that data gathering, research, and planning should recognize the existence of various types of runaways and homeless youth, who run away for different reasons and who require differential treatment.

In California, as in the nation, there are no typical runaways or homeless youth. They are most often between the ages of 12 and 18, and include males and females of all racial, ethnic, and socioeconomic groups. Several urban areas around the state have especially high concentrations of runaway and homeless youth. Participants at a recent California Youth Authority workshop offered the following general definitions of kinds of youth within the runaway and homeless population. These are not fixed categories, but descriptions of kinds of young people who are identifiable proportions of the runaway and homeless youth population, have particular profiles of risk factors, and pose systematic challenges for public and private helping agencies: street youth, rural youth, minority community youth, gay and lesbian youth, "baby" (younger, and usually first-time) runners, and missing children (both "voluntary" and abducted).[59]

Currently, public and private patchworks of organizations and agencies in local communities tend to provide services to runaway and homeless youth; systematic data about these arrangements are unavailable. Some state and federal initiatives and funds for planning and demonstration projects exist. Local police departments face mixed mandates and available resources in responding to these youth. In 1974, landmark federal legislation required the deinstitutionalization of status offenders and spurred the development of model programs. In 1976, AB 3121 prohibited all secure detention of status offenders—minors coming under the jurisdiction of the juvenile court under 601 WIC—including runaways; in 1977, AB 958 modified AB 3121 and restored secure detention of status offenders for specified periods under certain conditions. Recent state legislation continues the debate over enlarging the scope of secure detention of these young people or developing alternative strategies. Pending legislation would authorize law enforcement agencies to hold "status offenders" (truants and habitual runaways) in a secure facility for up to 72 hours, prior to alternative dispositions.

Findings from this workshop emphasized that there are no typical runaway and homeless youth.

> Their needs are as varied as the youth themselves. In California, we continue to debate between more lock-up and less lock-up for these youth. At most, the percentage of serious problem, street-oriented youth is about 25 percent of the total. . . The vast majority are not on the streets and do not have severe problems. We are talking about the youth who lives next door to you, maybe someone in your family; but young people who nevertheless need services.[60]

Children as Victims of Violence

Recent media attention to child abuse highlights one way in which children are the victims of physical and emotional violence.[61] Here we review the available indicators about direct violence done to children. As in other areas, such evidence is scant and unsystematic. Moreover, we are limited to discussion of children as the victims of reported crimes. We are also less able to discuss the indirect consequences for children of crimes committed against or by their parents. These consequences are many: emotional trauma, economic privation, notoriety or stigma, entry into state systems such as temporary foster care.

In 1986, there were 126 reported deaths from homicide among California's children under age 15. The number of child homicides has varied over the past twenty years from a low of 85 deaths in 1970 to a high of 144 deaths in 1977, with an annual total between 112 and 137 during the 1980s. Among infants under 1 year of age, 40 homicides were reported in 1982, the highest number of infant homicides yet recorded in California.[62]

The rate of child homicide has remained relatively stable from 1970 to 1986, varying between 1.6 and 2.6 per 100,000 children. The 1982 rate of 2.55 homicides per 100,000 children under age 15 was the highest reported rate in the last decade. Statistical analysis of these data suggest that the slight upward trend observable over time may not represent a real increase in the rate, but may only reflect chance and the variability in reporting deaths due to homicide.[63]

Conclusions

In sum, juvenile justice systems were established to enforce the standards of conduct believed necessary for the protection of individuals and the preservation of the community, in a way that maximized the flexible treatment of the youthful miscreant. These three—often competing—philosophies of juvenile justice come together in high relief in the current debates about overcrowding in state and county secure detention facilities, a result of explicit policy choices in recent years favoring high and increasing levels and lengths of confinement or incarceration.

At issue in the rehabilitation versus punishment and protection discussion is the dilemma that "the kid is a criminal, but the criminal is a kid."[84] Worthy treatment and rehabilitation objectives must be balanced against the need to protect the public, to communicate an appropriate social sanction for wrongdoing, and to effect restitution both to victims and to society at large. Institutions are expensive to operate and the burgeoning population of incarcerated juvenile offenders will require substantial operational and capital funding from the state. The impact of recent steeply rising costs associated with incarceration prompts further rethinking of the situation. As California reaches Proposition 4 (Gann) spending limits, increasing juvenile justice costs may mean reducing the state's ability to pay for other social services.

Policymakers, scholars, and juvenile justice officials have responded to these trends with conflicting reform measures. Although there is consensus that the juvenile system has failed to curb delinquency, there is little agreement on how to best correct its failures. Bolstered by studies that suggest rehabilitation does not work, some call for more punitive and deterrence-oriented approaches. Others argue that children must be protected from the harmful labeling effects of the system. Reform legislation in the 1970s often sought to satisfy both conservative and liberal interests. The debate continues.

Chapter 12

Income Support Programs

By Jacquelyn McCroskey

This chapter examines the two major income support programs for children—Aid to Families with Dependent Children (AFDC) and Child Support—and summarizes the operations of these two important programs and their potential effects on child recipients, particularly in light of ongoing efforts to reform the welfare system.

Government-sponsored income support programs for children provide families a source of last-resort financial support designed to ensure that children have at least minimum levels of food, clothing, and shelter. In California, the largest of these programs, Aid to Families with Dependent Children (AFDC), provides cash benefits to single-parent families and to two-parent families with an unemployed primary earner. The Child Support Program establishes and collects child support payments from absent parents for single-parent AFDC and non-AFDC families. The federal government plays a major role in the direction and financing of both programs, but leaves operation and administration to the states.

Income support programs, especially AFDC, account for a very large portion of the total public sector dollars spent on children's services at both state and county levels. In 1984–85, income support accounted for three-quarters of the children's budget of Los Angeles County.[1] However, these programs are important not only because of their impact on government budgets, but because of the unique service they provide for poor children. Cash support programs, unlike in-kind or service programs, help parents provide for their own children. AFDC provides crucial basic support for poor children and their families; it is both the cornerstone and the workhorse of the entire children's services system.

Although both AFDC and Child Support were originally devised to provide financial support for children, relatively little attention has been paid to their effects on child recipients. A great deal of data are available to document AFDC program accountability; reams of statistics are generated concerning eligibility standards, expenditures, and fraud prevention. Substantial research has been concentrated on characteristics of adult recipients and effects of AFDC on their work and marital status; however, very little of that data directly concerns children.

The standards of need used by income support programs do not reflect the norms one would like for every child. They provide minimums against which current parental means can be tested so that a minimum benefit can be calculated. They represent a theoretical floor below which no family should sink. No simple measure adequately captures the complexity of income distribution or the relative effects of income transfer programs. The statistics used to calculate poverty thresholds, rates, income levels, eligibility, and benefits not only are complex, but also tend to direct public attention to the inadequacies of program administration, rather than to the benefits provided to children.

The official poverty level established in the 1960s was based on the estimated cost of a diet that could sustain families of different sizes over a short-term crisis period. The cost of this "thrifty food plan" is multiplied by a factor of 3 since the "average" family is thought to spend about one-third of its income on food. Recent U.S. Department of Agriculture (USDA) studies have shown that five of every six families whose food expenditures meet this plan are still not eating nutritionally adequate diets.[2] So, these calculations produce a poverty-level benchmark that is too low. Setting income program payments by this standard provides only minimum support for children.

In 1987, the maximum annual cash benefit in California for a single parent with two children was $7,596 or 83.7 percent of the poverty line; a single-parent family of four was eligible for benefits equal to 77.7 percent of the poverty line. Adding the maximum food stamps benefit would have brought a family of three to just below the poverty line (99.3 percent). However, one in four of California's AFDC households did not receive food stamps, making California's the third lowest participation rate in the nation.[3] A

1982 survey of AFDC families in California showed both that only about 5 percent had incomes higher than the poverty level, and that these increases were due to the limited additional income earned by working parents.[4]

Benefits calculations for the AFDC program are based on a state-defined standard of need. California's need standard was more generous than that of any other state in 1970, but by 1987 twelve states had set more generous need standards, thus giving access to a broader range of families. However, only one other state (Alaska) set higher maximum benefit levels.[5] California is one of only four states that index benefits to inflation.[6] California also saw a 15 percent increase in the number of children receiving AFDC benefits between 1979 and 1984, a period when most states reduced or showed only small increases in the recipient population.[7]

Income support programs provide crucial services for children; they are, in fact, the cornerstone of the complex system of services whose purpose is to help move California's children into productive adult lives. Unfortunately, income services have more often been defined as ineffective programs for undeserving adults than as essential programs for over a million California children. About two-thirds of all AFDC recipients are children; in 1986, an average of 1,098,000 California children per month relied on AFDC for the daily basics of life. There were only about half as many adult recipients—an average of 565,000 per month.[8]

TABLE 12-1 Percentage of Population Receiving Income Support Services in California, Ten Other Large States, and the Nation, 1980–81 and 1985–86

	1980–81			1985–86		
	California	Ten Large States	Nation	California	Ten Large States	Nation
Percent receiving AFDC (or other public assistance)	13.6	13.3	11.9	14.1	13.8	12.0
Percent receiving food stamps	13.0	16.8	15.8	12.8	17.3	16.4
Percent receiving school lunch	20.5	21.9	21.7	22.4	22.2	22.5
Percent receiving child support	8.2	7.2	7.5	7.1	8.2	8.6

SOURCE: Current Population Surveys and Supplements, March 1980, 1981, 1985, and 1986.

Children Receiving Income Support

The Current Population Surveys (CPS) and the Supplements for March 1980, 1981, 1985, and 1986, compare families in California with those in ten other large states and the nation and provide illustrative data on children, including types of assistance received, mother's age, children's ages, parental education, poverty status, and ethnicity.

Table 12-1 shows the percent of CPS respondents receiving AFDC, child support, food stamps, or school lunch benefits in 1980–81 and 1985–86. (The category used for AFDC recipients is primarily made up of AFDC-recipient households, but also includes a small number receiving "other public assistance.") Across both time periods, about one in five respondents indicated that his or her child participated in the school lunch program. AFDC recipients increased slightly since 1980–81, and California showed a slightly larger percentage of recipients in both years than did the other large states or the nation. In 1985–86, California had fewer recipients of child support and food stamps than in the earlier years and had a smaller percentage of recipients in both programs than did other large states or the nation.

Table 12-2 shows selected characteristics of CPS respondents who received AFDC or child support. The contrast between AFDC recipients and those receiving child support is striking. AFDC recipients were younger, had less education and higher levels of poverty, were more likely to be nonwhite, and had younger children. The greatest changes over this time period were in regard to poverty levels. A much larger percentage of AFDC recipients reported incomes below the poverty level (from 53 percent in 1980–81 to 77 percent in 1985–86); over this same period, child support recipients reporting incomes below the poverty level increased from 9 percent to 15 percent. Clearly, the AFDC-recipient population in California is made up of families whose children would be greatly at risk without the financial support available through the AFDC program.

TABLE 12-2 Selected Characteristics of California Recipients of AFDC and Child Support, 1980–81 and 1985–86

	AFDC (or other public assistance)		Child Support	
	1980–81	1985–86	1980–81	1985–86
Mother's Age				
< 24	17%	17%	7%	7%
25–34	46	43	49	41
35–44	19	27	32	41
45+	9	8	8	6
Mother not present	9	5	4	5
Child's Age				
0–5	41	41	24	24
6–11	34	33	37	35
12–17	25	26	39	41
Parent Education				
< High school	48	51	12	10
High school graduate	34	33	34	32
Some college	12	13	29	32
College graduate or higher	6	2	25	26
Poverty Status				
Below poverty level	53	77	9	15
Poverty to 1.99 x poverty level	30	16	26	21
2.00 x poverty level and higher	17	7	65	64
Ethnicity				
White, non–Hispanic	36	29	75	74
Black, non–Hispanic	24	15	9	6
Other non-Hispanic	10	15	2	3
Hispanic	31	41	14	17

SOURCE: Current Population Surveys and Supplements, 1980, 1981, 1985, and 1986.

Aid to Families with Dependent Children (AFDC)

The oldest and most important income support program, Aid to Families with Dependent Children (AFDC), was established over fifty years ago by the Social Security Act of 1935. The original intent of providing cash assistance to needy fatherless children was reflected in the program's original title—Aid to Dependent Children. Federal assistance was increased in 1950 to include mothers at home caring for these children, and the program name was then changed to include "families." Although AFDC is still aimed primarily at supporting children (nationally, about two-thirds of the beneficiaries are children), most of the controversy about AFDC has centered on provision of benefits for parents. In the view of some, "welfare" has come to symbolize not the welfare of the children for whom the program was established, but the irresponsibility of their adult caretakers.

AFDC is federally mandated, but states exercise great latitude in program implementation, especially in setting standards of financial need and maximum levels of benefits. Benefits are administered at the local level by county welfare offices. The federal match varies among states, and the federal share of benefits payments is based on the Medicaid matching formula. The federal share ranges from a minimum of 50 percent to a maximum of 83 percent; nationally, about 54 percent of the AFDC benefit dollar comes from the federal level. In addition, the federal government pays half of administrative costs and 90 percent of the cost of developing and installing automated management information systems.[9] High levels of state and local participation in funding have encouraged local program decision making, resulting in great variation across states.

There have been substantial increases in income transfer expenditures for poor families since 1950, especially after President Johnson's 1965 declaration of War on Poverty. Although AFDC remains an extremely important part of our institutionalized response to needy children, it is by no means the only important income support program for poor families. The food stamp program now serves many more individuals and families than does AFDC. In 1987, almost 21 million people received food stamps (at a cost of about $11.6 billion), compared to the 11 million people who received AFDC (at a cost of $18 billion).[10]

National Data on the AFDC Program

Perhaps the most significant fact about the AFDC program is that, even though the cost of the program has increased steadily since the 1970s, the percentage of poor children who receive benefits has decreased. In 1973, about 80 percent of children living in poverty received AFDC benefits, but by the mid-1980s, only about 50 percent of poverty-level children did so.[11] The total cost of AFDC, including state and federal shares of direct benefits payments and administrative costs, has increased by over $10 billion since 1979, and the cost by 1990 (under current law) is projected to increase by $2.5 billion for a total of $20.7 billion.[12]

These contrasting figures explain why potential reform of the welfare system is a topic of considerable concern from all points of view. The number of poor children is increasing; although federal expenditures have increased, they have not kept pace with need. Drastic cutbacks in 1982–83 and a series of changes in eligibility rules eliminated some families and reduced some payments, but they also increased administrative costs and confused clients and agency employees alike. For example, a 1985 article in *Public Welfare* followed the effects of changing regulations in the case of a working mother in Georgia; between 1980 and 1983 her benefits were recalculated fourteen times, more than half of these recalculations due to changes in federal and state regulations.[13] The administrative complexity brought about by constantly changing the calculation and documentation of allowable benefits across states is staggering.

Federal outlays for benefits payments were estimated at $8.3 billion in 1986, with an additional $998 million for administrative costs; total federal and state expenditures were $15.8 billion for benefits and $1.9 billion for administration in that year. These dollars served 10.8 million individuals, of whom 7.2 million were children.[14]

There are three general categories of AFDC recipients: AFDC-FG, family groups made up of single parents and their children; AFDC-U or AFDC-UP, two-parent families where the primary earner works less than a hundred hours per month (California allows this benefit although about half of the states still do not); and AFDC-FC, children who do not have homes or have been removed from their homes due to inadequate parenting and who therefore reside in foster care or residential institutions. The cost of AFDC-FC has increased rapidly over this decade even though the number of children in placement has remained fairly stable. In 1980, federal expenditures of $217 million supported approximately 100,000 AFDC foster care children monthly; by 1987, federal expenditures had more than doubled to an estimated $592 million supporting about 109,000 foster children.[15] Californians accounted for about 21,300 of the total.[16] Although this amount is a relatively small component of AFDC, it is a crucially important link to the protective service and juvenile justice systems, allowing at least minimal financial support for children who cannot be maintained in their own homes.

AFDC in California

Since states set their own need and benefit standards, they differ greatly in their calculations of AFDC payments. California is no longer the leader it once was in the standard of need allowed for eligible families. In 1970, California maintained the highest AFDC need standard for a four-person family of all the states ($432), but by 1987 California's need standard of $734 had been surpassed by twelve other states. During this period, California increased its need standard by 69.9 percent while thirty-four other states increased their standards at much higher rates.[17]

However, in California more children receive benefits than in any other state, and grant levels remain high relative to other states. Over a million California children (1,098,000) received AFDC payments monthly in 1986; this represented about 15 percent of all children receiving AFDC in that year. New York had over 700,000 child recipients and only three other states (Illinois, Michigan, and Ohio) had even close to half the number of recipients in California.[18]

Table 12-3 shows growth in two components of California's AFDC program between 1979 and 1986.[19] The figures show a drop in participation in the AFDC-FG program following eligibility cuts in the 1981 Omnibus Budget Reconciliation Act. At the same time, there has been a steady increase in AFDC-U households. These two-parent households were also eligible for the maximum monthly food-stamps benefit; in 1987, a family of four could receive $290 monthly or 79¢ per person per meal.[20]

Why did these children receive AFDC? Data collected in 1983–84 on the approximately 547,000 AFDC families in the state illustrate the reasons for "deprivation" of children. About 40 percent of the parents in these families were not married, 17 percent had been married but were currently separated, and another 16 percent were legally separated or divorced. Only 13 percent reported two unemployed parents. Almost 4 percent reported an incapacitated parent, while about 3 percent reported a deceased parent.[21]

A recent study of children on welfare in Los Angeles County provides additional information on almost 400,000 child recipients of AFDC. Almost 44 percent of the children in that study were below age 6, 29.5 percent were between age 6 and 11, 15.9 percent were between age 12 and 15, and 10.6 percent were between age 16 and 18. About 87 percent of the children in the households studied received aid, but another 13 percent residing in the households did not receive aid through AFDC. Most of the children (65.5 percent) were in school; more than half (53.5 percent) of the

3- to 5-year-olds attended school but 16.2 percent of the older teens (ages 16 to 18) did not attend school. About half of the AFDC-FG children had been supported by AFDC their entire lives, while about one-quarter of the AFDC-U children had received aid their entire lives.[12]

The average benefit level differs considerably among the three AFDC programs in each California county. For example, in the quarter ending June 1986, the average monthly AFDC-FG payment per recipient statewide was $182.01, with a low of $159.01 in Mono County and a high of $190.32 in Los Angeles County. The average AFDC-U payment per recipient was $147.25, with a low of $110.41 in Mono County and a high of $155.08 in Los Angeles County. The average AFDC-FC payment was $784.79, with a low of $402.31 in Sierra County and a high of $1,448.43 in Inyo County.[13] These averages reflect an enormous range of need, as well as the administrative complexities of managing a large federally mandated program in a state that requires service delivery at the county level.

The need to document multiple program types and benefit levels in so many localities makes AFDC program monitoring extremely complex. Children's advocates and policymakers can easily become mired in the available data because, unlike many other children's programs where data are scarce, data on AFDC are abundant. Unfortunately, data at an extremely detailed level can obscure as readily as they illuminate. In the case of AFDC, the numbers routinely document expenditures, but they generally do not illustrate the effects of those expenditures on children and their families. Although available data often link AFDC to the food stamp program, another important income support program administered through county welfare departments, they generally do not include consideration of a related program that is structurally and administratively quite separate from AFDC — the child support program.

TABLE 12-3 Aid To Families With Dependent Children, California

		Number of Families		Number of Children		Average Grant		Maximum Grant	
		FG	U	FG	U	FG	U	Three-Person Family	Four-Person Family
July	1979	409,709	32,602	792,097	83,514	$353	$479	$410	$487
July	1980	421,411	46,489	805,455	116,937	412	535	468	557
July	1981	440,749	72,609	832,394	177,161	439	563	506	601
July	1982	428,313	78,597	775,671	189,239	410	554	506	601
July	1983	456,685	84,043	814,865	211,805	459	595	526	625
July	1984	462,087	77,770	830,390	205,884	488	653	555	660
Oct.	1985	482,297	72,946	876,251	200,465	515	714	587	698
Oct.	1986	492,626	77,566	897,892	211,941	524	707	617	734

SOURCE: California Department of Social Services, AFDC Surveys, 1979–1986.

The Child Support Enforcement Program

The Child Support Enforcement Program, enacted in January 1975 as Title IV-D of the Social Security Act, is a "federally supervised state and local effort to obtain child support payments for both AFDC and non-AFDC families."[24] Congress recognized the effects of lack of parental support on AFDC expenditures as early as 1950 with the requirement that state welfare agencies report the parental desertion or abandonment of children receiving AFDC. A quarter of a century later, Title IV-D established a national system to enforce the financial obligations of all parents to their children. Services include location of absent parents, establishment of paternity, and assistance in collecting court- or administration-ordered child support payments.

The values that inform this program were clear from the initial U.S. Senate Committee on Finance report: "The immediate result will be a lower cost to the taxpayer but, more importantly, as an effective support collection system is established, fathers will be deterred from deserting their families to welfare and children will be spared the effects of family breakup."[25]

Services are available both to families that do and families that do not currently receive AFDC. Nonrecipient families might thus be prevented from requiring AFDC as a "cost avoidance" measure. The primary program emphasis in most states, however, has been the reduction of AFDC expenditures. Payments for AFDC families are used to reimburse state and federal AFDC outlays, except for the first $50 collected each month. This exemption was established in the Child Support Enforcement Amendments of 1984, which strengthened the program by providing financial incentives for mothers' participation and by allowing more active collection efforts (such as tax refund intercepts and some wage withholding). The amendments also gave states financial incentives to increase child support collections for non-AFDC families who participate voluntarily and receive direct payments.

The majority of each state's administrative costs is paid by the federal government (70 percent through fiscal year 1987, but decreasing by about 2 percent in subsequent years). The federal program cost was $697 million in 1986 and is estimated at $771 million for 1987.[26] In 1985, more than $2.5 billion was collected through this system, about $1 billion of which was for AFDC recipients.[27]

Although each state must designate a separate Title IV-D agency within the state, these agencies may and do set up different administrative structures. Administration and performance vary across states. A 1983 state-by-state review found substantial room for improvement in both AFDC and non-AFDC collections. The Office of Child Support Enforcement found that on average, nationally, $2.93 was returned in support payments for every dollar spent administering the program. California was one of the states below the national average for both kinds of cases, with an average $2 return for each dollar invested. The range was quite broad: Iowa showed a $4.91 return while the District of Columbia recovered only $0.71 in return for each dollar spent.[28]

Only 58 percent of mothers with children under age 21, or a little over five million women in 1984, were awarded support and only about four million of those actually received payments. About one-half of these mothers received the full amount of the award. The average amount for those who received payments was $2,341 or about 18 percent of their average total income.[29] White women were more likely to receive payments than were black or Hispanic women, and women with higher education also received more payments. About 15 percent of AFDC recipients received child support in 1981, while another 13 percent were granted awards that went unpaid.[30]

The achievements of the Child Support Program to date are promising but inconclusive. Weitzman reports that "not one study has found a state or county in which even half of the fathers fully comply with court orders."[31] Improved enforcement could make a difference both for families and for the public coffers. For example, Robins reports that, although child support cannot be expected to move families off AFDC altogether (partially because of low award amounts), full enforcement could substantially reduce AFDC costs. He maintains that a successful system, which would include wage withholding as well as greater establishment of payment obligations, could recover between 15 and 20 percent of AFDC benefits.[32] Other analysts estimated the potential financial benefits of an effective child support collection system even higher, suggesting that poverty could be reduced by 30 to 40 percent and AFDC caseloads could be decreased by 20 to 50 percent.[33] This potential makes it worthwhile in most states, and certainly in California, to more carefully evaluate the success of current child support policies and to consider alternative program arrangements.

Child Support Enforcement in California

Several agencies are involved in California's child support efforts. The state Department of Social Services (DSS) is the designated Title IV-D agency. The Office of the Attorney General coordinates Parent Locator Services. At the county level, the Child Support Enforcement Program is administered by the district attorney, who works on the basis of court orders fixing support amounts. A 1984 state law (AB 1527) set minimum awards based on AFDC amounts, giving encouragement to set a higher-than-minimum award if possible. Average awards in California provide only minimum subsistence, according to federal poverty guidelines. The average monthly child support payment in California for the first quarter of 1986 was $159.74, while the U.S. poverty guideline was $150 per month per child. California's average was less than the national median child support payment of $194 per month.[34]

Child support collections have increased in recent years. In 1982, California collected $247,023,000. By 1986, the total collected had increased by 27 percent to $337,870,000.[35] The program does produce a revenue offset for the state. According to DSS, in 1984–85 the percentage of AFDC costs recouped was 5.8 percent statewide. Child support collections for AFDC families were $174 million while overall AFDC-FG expenditures amounted to over $3 billion. In 1985–86, about $59 million of the $337 million collected offset state costs for the AFDC program.[36]

About 11 percent of AFDC families in 1986 benefited directly from the $50 passthrough.[37] Even so, those studying the California system have pointed out its shortcomings and attested to the need for systemic changes.[38] California's number of initiated actions is greater than that of any other state (approximately one-third more than the next highest states), but improvement in areas such as establishing paternity, increasing the standard of need, and judicial training has been recommended to improve the financial well-being of children.

Tables 12-4 and 12-5, taken from data in the annual reports of the California Child Support Information System since 1978–79, illustrate changes in the system over the past decade. The total number of cases has not changed greatly but the percent of active non-AFDC cases has increased from 15 percent in 1978–79 to 31 percent in 1984–85. Total collections processed have increased almost twofold while the number of support-paying cases has increased by 23 percent. The average monthly support payment has increased by almost $50, but has just kept pace with inflation.[39]

Reforming Child Support: The Wisconsin Demonstration

A demonstration program underway in Wisconsin raises some important questions about the potential impact of a model child support program on poverty among single-parent households as well as on welfare expenditures. The Wisconsin Child Support Assurance Program includes a simple formula to determine award amounts—collection through withholding and assured benefits. The formula is a percent of the absent parent's gross income: 17

TABLE 12–4 Changes in the California Child Support Program, 1978–79 to 1984–85

	1978–79	1979–80	1981–82	1983–84	1984–85
Child support case load (active cases first of year)					
Total[a]	945,513	979,704	914,907	957,783	942,248
AFDC	769,210	786,204	575,584	603,075	584,040
Non-AFDC	144,751	145,380	275,116	291,896	294,667
Location of absent parents (cases opened)					
Total[a]	102,390	115,706	106,952	115,820	122,769
AFDC	94,876	104,410	93,131	100,670	103,367
Non-AFDC	6,177	10,118	8,942	10,005	11,808
Establishment of paternity (cases opened)					
Total[a]	81,449	99,578	81,749	60,474	65,620
AFDC	77,132	91,804	74,906	52,068	55,810
Non-AFDC	3,218	5,640	5,680	6,950	8,103
Establishment of support obligations (cases opened)					
Total[a]	263,661	187,578	155,451	111,393	123,460
AFDC	238,550	163,514	126,488	86,149	94,604
Non-AFDC	13,405	12,658	15,949	14,320	17,662

[a] AFDC and non-AFDC do not equal total, since this table does not include responding cases where welfare/nonwelfare status were not known by counties.

Note: Figures for 1980–81 and 1982–83 were not available.

SOURCE: Child Support Management Information System, Annual Reports, 1978–79 to 1984–85.

TABLE 12-5 California Child Support Collections, Cases and Average Monthly Support Payments, 1978-79 to 1984-85

	1978–79	1979–80	1981–82	1983–84	1984–85	Percent Change 1978–79 to 1984–85
Total collections processed	$192,632,069	$214,476,545	$245,146,072	$317,926,332	$355,436,242	+84%
Child support-paying cases processed	1,670,190	1,773,284	2,086,216	2,030,863	2,158,999	+29%
Average monthly support payments	$115.34	$119.82	$117.51	$156.55	$164.63	+43%

Note: Figures for 1980–1981 and 1983–1984 were not available.

SOURCE: Child Support Management Information System, Annual Reports, 1978–79 to 1984–85.

percent for one child, 25 percent for two, 29 percent for three, 31 percent for four, and 34 percent for five or more children. This amount is automatically withheld from the paycheck where possible. All children in single-parent families are entitled to this amount or to a publicly assured child support benefit, whichever is larger. Low-income caretakers can also receive child care expenses of $1 per hour for one child or $1.75 for two or more children.

The Institute for Research on Poverty, which suggested and designed the program, estimates that these standards will reduce poverty among families with eligible children by about 30 percent and will reduce AFDC caseloads by 20 percent if the state "funnels all AFDC savings from enhanced collections back into the system."[40] If enforced nationally, "the poverty gap could be reduced by 24 percent and AFDC caseloads by 29 percent."[41]

Results of the Wisconsin program will undoubtedly influence child support policies in other states in the years to come. Child support enforcement is a relatively new governmental program; it has been implemented unevenly, but its philosophy is persuasive. It is a universal program that provides a modest supplement to AFDC-recipient families, along with a cost retrieval for state and federal governments, and it provides needed support for children in non-AFDC single-parent families. Perhaps most importantly, it underlines the continuing responsibilities of both parents to care for and support their children.

Effects on Children

It is self-evident that programs that provide basic food and shelter for children are beneficial for both children and society; however, many questions remain unanswered, such as, how can institutions charged with providing basic support for children be most effective? Do those very institutions at times bring about unintended negative consequences for children?

Very little information allows us to compare the effects of different kinds of income support programs on young recipients. Studies such as the Seattle-Denver Income Maintenance Experiment have primarily examined the effects of varying benefit levels and program criteria on adult behaviors, such as growth of single-parent families and rates of remarriage. Very little of this research has looked at the effects that receipt or nonreceipt of program benefits have on children or the influence of alternative methods of providing income support. In fact, very few child outcome measures, beyond the possibility of intergenerational transmission of welfare dependence, have been studied. This is perhaps not surprising since the major public policy debates have centered on whether and under what conditions government should provide for adults (even if they are identified as caretakers of young children) and not whether children deserve support.

A good deal of research has focused on how deprivation, especially long-term poverty, limits childhood development. In many of these studies, poverty has been operationalized using receipt of AFDC as a variable. No studies contrast AFDC with child support, or test program modifications based on their effects on children.

One difficulty with trying to separate the effects of income support programs is that these programs are directly linked to class and race. Recipients are both socially and financially disadvantaged. In California, black, Hispanic, and Asian-Pacific families are all disproportionately represented among the poor, and are therefore more likely to rely on the welfare system for income support.

Even with its limitations, available research does suggest that income support programs may have some effect on children's mental health and future attainments. In terms of the mental health of adults, some evidence suggests that welfare recipient status is associated with low self-esteem, feelings of loss of control, and depression. For example, Goodban reports that black single mothers on welfare felt "trapped, unable to break out of the system, guilty and ashamed because they could not seem to succeed no matter how hard they tried."[42] Many studies link children's well-being and development to their mothers' mental health; one study found that mothers with more depressive symptoms were less responsive, less nurturing, and more punitive toward their children.[43]

An anomalous finding in a study of depression among low-income female-headed households, most of which were AFDC recipients, is intriguing. Women with *high* depression scores were *less* likely to report stress in dealing with the welfare system. The investigators speculated that these women "have accommodated themselves more completely to a loss of privacy and control. An alternative hypothesis is that depression indicates an inability to express anger. They may in fact be considered 'good recipients' compared to women who are not depressed."[44] To the extent that the welfare system accommodates or encourages such depression, children's development may suffer.

Some recent studies present a marked contrast to the research agenda of the last two decades by focusing on the "invulnerability" and "resilience" of some children even under conditions of chronic poverty, disorganization, and ill health.[45] Almost all studies in this area define poverty either as a barrier or a mitigating factor in the development of a resilient or invulnerable child. For example, the Rochester Longitudinal Study, which examined the impact of maternal mental illness (especially schizophrenia) and social status, found some similarities between children of mentally ill mothers and those from lower-social-status homes. The negative impact was longer lasting for those with mentally ill parents, leading the researchers to suggest that lower social status may simply delay childhood achievements. They also noted that these are often not separate conditions; the prevalence of mental illness is much higher among families in lower socioeconomic groups.[46]

Both poverty and single-parent-household status have also been linked to limited adult attainments, but the data are mixed. It appears that children of single mothers are less likely to remain in high school, but there is no clear evidence that these children ultimately achieve less occupationally.[47]

Teen mothers appear to be especially at risk in terms of educational attainments. Many drop out of school altogether or pursue less rigorous equivalency degrees. A longitudinal study of adolescent mothers in Baltimore has found that, although most mothers were still quite "unsettled" five years after pregnancy, many had made unpredicted gains seventeen years later.[48] Over half had attended school for at least a short time. About a third of these mothers did rely on welfare early on (compared to 5 percent of their classmates who were not pregnant), and 70 percent received some welfare during the course of the study. By the second follow-up period, two-thirds were off welfare. Many of the study findings seem to indicate that the long term may not be quite as dire for adolescent mothers as shorter-term studies have predicted. This is especially important since about two-thirds of teen mothers nationally spend some time on welfare, and expenditures on their behalf account for about half of all AFDC expenditures.[49]

The study also examined educational outcomes for children of teen mothers. Children of mothers who received welfare both as children and during early motherhood had much lower scores on achievement and skills scores in preschool and significantly increased chances of school failure. For children of mothers still on welfare at the second measuring point, the likelihood of school failure was tripled.[50]

Most recipients recognize the difficulties of completing an education while on welfare. A study comparing the attitudes of current welfare recipients whose mothers were also recipients with those whose mothers were not, found only one area of difference—those from two-generation welfare families valued education more highly.[51]

Because higher income is associated with increased educational and occupational attainment, the question of whether welfare receipt that increases family income also has additional positive effects on children is important. Duncan, Hill, and Hoffman conclude that the evidence is too mixed at this point to afford a reliable answer.[52]

This question is only one of a number that warrant further study both in California and across the nation. Research is needed to address the effects on children of current welfare programs and possible alternatives. For example, do recipients enrolled in job training programs feel increased self-esteem as a result of their accomplishments and, if so, does this benefit their children? Are there noneconomic advantages to children of paternal financial participation through payment of child support in terms of self-concept or behavior? Are these different for AFDC-recipient children in comparison to their counterparts in non-AFDC families? The Seattle-Denver Income Maintenance Experiment produced a wealth of data on the effects of alternative welfare arrangements on adult marital and household formation behavior; the data have been analyzed from several points of view and provide crucial information on how welfare works for adults.[53] A similar approach is needed to assess its effects on children.

Welfare Reform in California

In its promotional materials, the California Welfare Reform Program is called "an historic bipartisan program" and, indeed, Greater Avenues to Independence (GAIN) pioneers many of the ideas still debated at the federal level. True welfare reform on the scale originally envisaged requires a substantial investment of state dollars. A good deal of uncertainty still lingers about the level of investment Californians are prepared to make in GAIN. Original estimates called for California to spend about $408 million on GAIN in 1988–89, 60 percent of which would come from state general funds. In its heyday, the federal Work Incentive Program (WIN) spent less than $390 million per year.[54] GAIN implementation was planned to take five years, so the program will not be fully operational until September 1990. The effort is an extremely important one, both in terms of its potential impact on California's children and their families and as a national model. However, it is also important to ensure that expectations of this program are realistic. In order to achieve an "historic bipartisan" compromise, promises may have been overestimated, while the potential pitfalls were played down.

Historically, efforts at welfare reform have been frustrating and only marginally successful. In general, the more incremental the reform, the more likely has been its chance of acceptance. In the 1960s, welfare amendments, which allowed recipients to deduct the first $30 of gross income and one-third of remaining earned income from benefits calculation and that set up the voluntary WIN employment and training program, were the first significant efforts at "reforming" AFDC. WIN was made mandatory for all those who were "employment ready" – essentially those who had school-age children or who were heads of two-parent households. Other changes have been made to WIN, but it has never become the kind of employment program envisaged by proponents anxious to control increasing AFDC caseloads, at least in part because the links between training and job placement have not been secure enough.[55]

The 1981 Omnibus Budget Reconciliation Act (OBRA) authorized states to set up alternatives to WIN, and by 1987, forty-two states had instituted one or more of these optional "demonstration" programs, providing an array of program models and some evaluation of program effects. WIN demonstration programs receive 90 percent federal funding, while other available options (such as community work experience programs, employment search, or work supplementation) are matched at 50 percent. Clearly, these state programs are heavily dependent on federal funds, and thus are vulnerable to federal cutbacks. Such cutbacks have been significant – WIN, for example, was cut by 70 percent between 1981 and 1987. Such demonstration programs have reached only a minority of AFDC recipients; in 1985, an estimated 22 percent of adult recipients in those states with full-year programs were served.[56] The most widely available service was job search, which does not improve job skills. Major program limitations are, of course, linked to funding; three-fourths of the WIN demonstration programs in 1985 spent less than $600 per participant.[57]

Current discussions are greatly informed by evaluation data from some of the state optional employment training and "workfare" programs. The Manpower Development Research Corporation (MDRC) has been conducting a careful five-year study of programs in eleven states. Its interim results illustrate both the complexity of program documentation and the effects of multiple program types on recipient behaviors.[58] Gueron[59] concludes that a wide range of approaches can be effective, that impacts are greater for recipients without recent work experience, and that the program seems to lead to "relatively modest" increases in employment. Programs appear to provide a useful work experience, and future savings offset costs, but the work assignments do not necessarily provide skills that ensure wages adequate to support a family.

In the San Diego program (whose experimental design is the best of all trials thus far), differences in AFDC enrollment were due to increased rates of employment, not to differences in wage rates; effects were greatest for those with little or no previous employment experience, and the work requirement did not appear to deter people from continuing on welfare.[60] Specifically, 61 percent of the workfare participants found jobs, compared with 60.4 percent of those who participated only in the job search activities, while only 55 percent of the control group found work. Researchers caution that welfare is a complex program addressing an even more complex problem; work initiatives are not the single answer to reforming welfare.

Although the results are not yet fully gathered on job search and employment training programs for AFDC recipients, the consistent early indications are that these programs can be effective in increasing earnings of economically disadvantaged women, especially those who have not had recent work experience.[61]

Debates on federal and state welfare reform are clearly informed by these early results.

While GAIN builds on the San Diego County experience and other WIN demonstrations, it is even more ambitious. It offers a wider, more comprehensive range of services, including job search, basic adult education, English as a second language, career assessment, vocational education and training, on-the-job training, supported work, transitional, employment, and preemployment preparation. It also provides child care, transportation, and other support services to participants. It interacts with a much larger proportion of the AFDC caseload (mandatory participants include parents with children over age 6); it establishes specific criteria for exempt and deferred participants, assuring broad participation. GAIN requires the continuous participation of recipients in one or more program activities until recipients are employed or off welfare; these requirements are assessed individually, formalized in a contract, and monitored by a case manager.

GAIN will be scaled down somewhat as the realities of implementing this complex program become apparent. Experiences in the early counties have underscored the dynamism of the AFDC caseload; up to 60 percent of GAIN clients are gone within the first three months (having found employment or been determined ineligible). A much greater need for remedial education has also lessened the projected need for child care, at least temporarily, while the school hours of mothers match those of their children.[62]

Planning is proceeding in all fifty-eight California counties, but as of April 1988 only twenty-eight of the counties were operating GAIN. The Manpower Development Research Corporation has been contracted to evaluate the entire effort by 1992; its first report on planning and early implementation contains hopeful signs of progress, although findings were necessarily limited.[63]

The intent of GAIN is to advance farther than previous programs by mandating and following through to ensure participation, individualizing assessment, offering choice in the range of possible activities, and guaranteeing that participants get the services they need from a coordinated system. Broadening the focus of the income support system may be one of the most important aspects of the program. Initiating formal relationships between county welfare departments and economic development departments, community colleges, adult schools, regional occupational centers, child care programs, Job Training Partnership Act (JTPA) programs, and other major service systems is extremely difficult in the larger counties, but these relationships may bring a fragmented system into closer alignment, an outcome that could have substantial long-term benefits for California's families.

To the extent that the more than five hundred agencies and organizations expected to contribute to GAIN statewide have vested economic interests, they may play a more active role in ensuring that integrated service delivery works. If so, GAIN program implementation may provide a model for government interdepartmental coordination, as well as public and private sector coordination; this kind of planning and service delivery is needed in almost every program area. If the systems could be more effectively coordinated to meet the multiple needs of families, rather than concentrated on unique service delivery mandates, this achievement would be significant indeed.

However, none of the outcome measures currently in place addresses the potential effects of the program on its child recipients. The state is planning a study of the child care implications of GAIN to be completed by MDRC in the spring of 1989; this will add to existing knowledge of how child care program components work. Efforts to address other questions about the effects of income support programs on California's children would also be useful. For example, does GAIN participation by mothers improve educational outcomes for their children? Do fathers who pay child support also participate more in other aspects of child rearing? Do negative feelings about legal enforcement of child support obligations create hostility and resentment, which are taken out on children?

Do children benefit from the increased self-esteem and accomplishments of their mothers during job training or subsequent employment? How do different kinds of supervision—mother at home, informal child care arrangements with relatives or friends, licensed child care—affect children's educational achievements? For older children, does supervision decrease the possibility of drug use, gang activity, and teen pregnancy? How do families who get off welfare manage over the long term? Do they remain self-sufficient? And finally, collaboration between researchers interested in children and those evaluating the cost-benefit outcomes for adult recipients would be an important step forward, allowing California policymakers to more fully assess the multidimensional impacts of welfare reform.

Conclusion

Although data on the Child Support Enforcement and AFDC programs in California are collected and analyzed separately, the two are clearly interconnected. In a recent analysis for the Los Angeles Roundtable for Children, this author compared budget and caseload data on both programs run by the county government. Since the Department of Public Social Services counted individual recipients while the district attorney counted recipient households (each household had at least one child but an unknown number had more), numbers were not directly comparable. The report stated that in Los Angeles County:

> approximately half of the families for whom collections are made are AFDC recipients and, even more startling, collections are being made for about half of the children on AFDC (52 percent in 1980–81, 49 percent in 1981–82, and 42 percent in 1984–85). However, although the two programs are equivalent in numbers served, the average collection made per household does not approximate the size of an AFDC grant."[64]

Establishing closer administrative linkages between the Department of Social Services' AFDC program and the district attorney's Child Support Enforcement Program (both statewide and on a county level) would make it easier to plan for and track program complementarity.

The effects of these programs also have a bearing on the services provided by other governmental departments since increasing numbers of children have multiple service needs. Although data collection systems are not yet at the point at which individual children can be tracked across programs, it should be possible to develop better methods of aggregating data across programs serving children in order to begin to understand the connections between systems. Conceptual and administrative relationships between systems should reflect the real needs of families and children rather than the convenience of traditional departmental categories. All children have common health, educational, and developmental needs, and many of California's poorest families also have difficulty protecting their children from environmental or family problems. Aggregating data across departments can help policymakers understand the relationships, for example, between adequate income support and use of child care or child abuse or juvenile delinquency services.

Income support programs raise a basic question about the nature of governmental responsibility toward children. Should government ensure that every child is welcomed and provided for through an entitlement, such as the children's allowances provided in some European countries? On the whole, the United States has resisted the idea of entitlements for children and has provided income support using limited, means-tested eligibility criteria. These services have generally been provided only on the condition that government be allowed to exert social control over the lives of recipient families.[65] In recent years, reductions in eligibility and benefit standards have also meant that the recipient pool is made up of increasingly poorer children. Even so, program costs and numbers of recipients have grown.

A changing economy, along with recognition of the current welfare system's inadequacies, has rekindled debate on income support policies. Is it the purpose of income support programs to provide a minimum acceptable level below which no child shall be allowed to fall, or is it their purpose to ensure that parents achieve economic independence? Should all parents retain the economic responsibility of providing for their children, regardless of their ability to fulfill that responsibility? What kinds of strings (for example, parental work obligations) should be attached to income support programs?

States set their own need standards and benefit levels for AFDC and child support collections; so, although federal dollars play a major role in determining benefits, California retains important options about how income support is calculated and administered. The counties also have some latitude in administrative arrangements. Californians at state and county levels can decide to link income support programs much more closely to other children's services programs, for example, in such areas as data collection and ongoing program evaluation.

The outcomes of Wisconsin's child support demonstration program will undoubtedly have national implications. Child support is closely tied to AFDC, but in California it is administered quite separately. Although child support offers some cost recovery to offset government expenditures on AFDC, it can also help prevent the need for public support of other potentially needy families. Placing equal emphasis on AFDC-recipient and nonrecipient families should not prevent closer administrative and informational linkages between the welfare department and the district attorney's office.

Poor children face greater risks in many areas than do children of more affluent families; as the number of poor children grows and poverty deepens, the risks for the children and for California increase. Renewed concentration on providing families with the basics that can prevent later problems is sensible. Income support programs that act as "insurance against temporary misfortune"[86] play an important role in preventing many serious and costly problems for children. Assessment of their effectiveness will, therefore, continue to be crucial to an accurate determination of the condition of California's children.

Chapter 13

Policies for Children with Multiple Needs

By Shirley Brice Heath
Milbrey Wallin McLaughlin

All children have multiple and diverse needs as they grow up, needs that must be met by some mix of private and public resources. For most children, the parent is the prime caregiver, providing numerous types of support both inside the home and "brokering" various resources outside the home—recreational activities, medical care, and counseling, for example. However, the extent to which in-home supports or out-of-home services are made available or are applied effectively to children varies by the capabilities, knowledge, and motivations of parents. For some children, especially children of advantaged family backgrounds, parents attend to the multiple aspects of a child's productive development—providing a nurturing home environment and purchasing or facilitating out-of-home services or resources as necessary. These parental decisions and choices generally reflect (1) a broad view of the maturing child and (2) implicit if not explicit integration of the multiple needs and challenges children encounter as they develop.

However, for less-advantaged children, this parental support and active involvement is not reliably available. Public services play a crucial role in the development of such children. Yet these children typically confront a pattern of services that is not designed or equipped to provide multiple services effectively, both because the parent's view of the developing child largely is absent and because the level of available public services generally is insufficient to meet the needs of children.

This chapter is derived in large part from the conditions and trends reported in all the preceding chapters that analyze the public and private delivery systems for California's children. The preceding chapters demonstrate that as regards children who are vulnerable and in need of several services, the problems of effective service delivery are practical, structural, and conceptual. They include (1) a lack of access to preventive services; (2) a failure to help or hold children over several years as they develop; (3) a failure to meet enough of a client's multiple needs to assure a satisfactory outcome; and (4) a lack of integration or coordination across service areas. All service sectors show a crucial imbalance favoring acute care over preventive or developmental services. This de facto definition of the "problem" as short-term and compartmentalized is compounded by an absence of any system of longitudinal recordkeeping or assessment. These barriers make evaluation of effectiveness and communication across service areas virtually impossible. And these problems will become even more acute as the California child population changes in the future (Chapters 2, 3, and 4).

How did California's policy structure for children get into such a sorry state? As we shall outline, the general problems include separate funding streams, inconsistent eligibility criteria, splintered organization of interest groups, and legislative jurisdictions that preserve service fragmentation. In addition, observers both within and beyond California direct their criticism to the point that California's policies have not kept pace with the state's current and projected demographic picture of altered family life. Changing demographic characteristics have driven policymakers to respond to the needs of separate institutions that plead for segmented state action and funding.

Yet the actual problems confronted by users or clients of the state's resources for children exhibit a pattern of need and an everyday reality antithetical to neat bureaucratic divisions or professional boundaries. Consider the San Francisco family of six foster children headed by a severely disabled 67-year-old woman.[1] The family lives in public housing, receives financial assistance, and receives services from multiple agencies. The broad array and diversity of the agencies is reflected as follows. The Department of Social Services (DSS) is involved with the foster children; the woman has a DSS worker from the Adults Division. San Francisco General Hospital Family Health Center is the health care provider for the woman and many of the children. Staff of the Visiting Nurses Association (VNA) of San Francisco make regular visits to the woman, and a public health nurse visits the 14-year-old teen mother. The Teenage Pregnancy and Parenting Program (TAPP) and the San Francisco Unified School District provide special services to this teen. The San Francisco General Hospital Early Parenting Program also provides services to this teenage mother. Some of the older children who have drug problems have been involved with the police and have received drug rehabilitation program services. There have been reports that the younger foster children are having school problems, and one of the foster children has been recently placed in a special education program. All the foster children have either Big Brothers or Big Sisters.

Another San Francisco family unit illustrates different but equally complex needs. A chronically depressed AFDC mother of two girls (ages 3 and 5) separated from her second husband two years ago after he abducted and molested the 3-year-old. He was arrested on another charge and jailed briefly. Subsequently, the 5-year-old, who had become increasingly withdrawn and had developed behavioral problems, revealed she had been molested by an older relative.

As the family's problems surfaced and became more acute, the mother sought help from several sources. She needed mental health services for her two children, who were both showing symptoms of emotional distress. Her older daughter needed medical care for asthma, and her own deepening depression needed attention. She tried unsuccessfully to obtain public housing in a different area to escape the constant reminders and harassment in her old neighborhood. She also sought day care and after-school care for her children to enable her to finish her education and find a job. Again, she was unsuccessful, partly because she did not know where she would be living. The father of the younger girl pursued visitation rights through the Family Court, and Legal Services for Children became involved to represent the child.

These cases of multiple, interrelated needs are not unusual in California and elsewhere. Lawyers, psychiatrists, physicians, and mental health professionals—each in their own way, and within the context of their particular involvement—provide fragmented case management efforts to obtain day care, housing, school transfer, and so on. As a result there is duplication, confusion, and unnecessary use of costly, professional time. There also is a fundamental failure to confront the broader needs of children that generate particular social service demands such as child abuse.

Also lost in this fragmented approach is an opportunity for the professionals responsible for providing children's services to observe or acknowledge how their organizations affect the everyday life of California children and their families. This look at the daily lives of children would reveal that public resources for children in California are inadequate not only because of their bureaucratized and fragmented nature but also because they are insufficiently supported. The preceding chapters stress that poverty, juvenile incarceration, and child care demands are increasing, while children's service organizations are not only overloaded and underfunded but also static and out-of-sync with dynamic societal changes. For example, supplemental income programs that serve children and their families have been severely affected by federal cutbacks. As McCroskey (Chapter 12) notes, an estimated 1.5 million children nationally no longer receive subsidized meals at school. The federally administered Aid for Families with Dependent Children (AFDC) program has been cut by $7 billion since 1980. Proposition 13 has made it very difficult to impossible for counties and school districts to raise local funds for social services generally.[2] As a case in point, Ventresca and David (Chapter 11) describe the debilitating effects on juvenile justice programs of the joint effects of Proposition 13 and elimination of the federally supported Law Enforcement Administration Agency (LEAA)—local probation caseloads have swelled to more than a hundred in urban areas.

The capacity of local governments to support mental health, counseling, child welfare, and other youth-serving policies must increase (as Chapters 2, 3, and 4 demonstrate), but they cannot meet these challenges given the dysfunctions of the current fragmented service system.

From day care regulation to proposals for state-mandated volunteer efforts by college students, public policymakers have noted problems and suggested solutions. Implicit in all these efforts has been the recognition that agents of change in the lives of California children must not only move beyond the family and the school—the traditional guardians of children throughout United States history—but also must develop new conceptualizations of integrated systems and services as resources for children. More money for the existing melange of programs will not provide the crucial improvement for children with multiple needs. Nor can any single entity, such as school or family, deal effectively with interrelated youth problems.

The preceding chapters indicate more than problems of inadequate funding or technical expertise. These chapters raise questions regarding program design and conduct, and point out problems such as the types and sources of data available for decision making and the tendency to accept certain assumptions about the separate components of children's daily lives. The authors describe problems deeply rooted in the way services are provided in various areas, in how the needs to which policies respond are conceptualized, in what information is *not* available to inform policy and practice, and in the effective implementation of youth policies within the broader policy systems.

Problems of Providing Services

Two broad problems of service delivery are evident in the preceding reviews and analyses of California's youth services and policies: *underservice* and *service fragmentation*. Across child abuse, mental health, child care, and other domains of youth policy, the numbers allow a clear conclusion: a substantial portion of needy youth are now either unserved or underserved. For example, as Grubb (Chapter 5) elaborates, despite the innovative reputation of California's child care system, a significant number of families find adequate child care either inaccessible or unaffordable. Demand in this important area by low-income parents far outstrips supply as the system responds slowly to changed family circumstances. McCroskey (Chapter 12) details the extent to which the supplemental income programs for children and their families fall short of minimal needs. Barth (Chapter 10) demonstrates that the child abuse treatment system often cannot respond quickly enough to the sharply rising number of reports. Halfon and his colleagues (Chapter 9) describe the crucial gaps in health services available to California's children and youth—services for children between the ages of 2 and 5, for example. Every chapter highlights the lack of early trouble prevention and the consequent high costs and limited impact of intervention when children are already in deep trouble.

Problems in the level of support for children's services are joined with problems in the nature of those services. Accounts of programs for children in health, welfare, juvenile justice, and social services reinforce the conclusions of The Little Hoover Commission: programs for children and youth must be integrated.[3] Each chapter bears witness to the isolation, balkanization, and lack of coordination among the agencies responsible for serving youth.

The consequences of such a compartmentalized approach to youth policy are children and families who fall between the cracks of various administrative definitions of "the problem," redundant or overlapping services such as the multiple tests administered to children requiring special education, and the absolute loss of financial support for children as district attorney's offices and departments of social services debate responsibility for securing child support payments. Existing services do not meet important needs of children and their families. For example, a child with multiple problems too often receives a programmatic label (*substance abuser*, *delinquent*, *dropout*, or *teen parent*, for example) that misrepresents or oversimplifies the nature of his or her troubles and obstructs comprehensive assessment or response. Furthermore, analyses of the condition of children from the perspective of the various service domains portray various implementation problems rooted deeply in the realities of public policymaking and the politics of bureaucratic maintenance.

All these difficulties are monuments to the single-issue policies and single-issue solutions that dominate this nation's social policies. California's youth policies, as those in other states, were developed ad hoc, as problems were "discovered," with little consideration of the existing policy configuration. In part, California policies are determined by the disjointed nature of federal policies, as illustrated in a recent San Francisco report.[4] State and local policies confound this complexity. For example, the City and County of San Francisco has no unifying vision, master plan, or explicit goals and objectives governing the allocation of funds or delivery of services to children, families, and youth. Few San Francisco city departments have developed mission statements or department-wide master plans for children that identify the department's goals and objectives; govern their planning, resource allocation, and service delivery systems; assess the effectiveness of their efforts; or coordinate the activities of individual divisions within the department.

The result is a collection of loosely connected departments, agencies, advisory boards, and commissions. It is a nonsystem that appears to be driven by financial considerations and response to crisis rather than by clearly defined and mutually endorsed community values. As such, it is a system that increasingly focuses on symptoms rather than causes, reacting rather than planning.

San Francisco's human service departments rely heavily on services provided by numerous private, nonprofit community agencies, which frequently build their services around those provided by public human service departments. These private, nonprofit organizations provide important services to consumers in all of the city's departments, and they are essentially excluded from the planning process.

When children and youth move from one level of care to another—for example, from home to detention in juvenile hall, from inpatient psychiatric hospitalization to residential treatment, or from dependency to emancipation—they move in and out of different departmental jurisdictions, encountering different groups of service providers who do not follow them to the next level of care. If San Francisco's service systems were better coordinated, high-risk families, children, and youth would be part of a system of care that responded to their needs knowledgeably and consistently regardless of their place in the service continuum.

However, policies and programs for youth in California are driven largely by political definitions of the problem and administrative definitions of the solution—specific responses to specific problems—rather than a by consideration of the aggregate policy environment for children.[5] This political reality exacts absolute costs in terms of efficiency, effectiveness, and adaptability of services for children in California.

The symptoms of dysfunction are multiple and complex. There are the problems associated with programs authorized by different levels of government. McCroskey's analysis of income programs (Chapter 12) illustrates the issues associated with merging federal and state eligibility requirements, for example. But even more problematic from the perspective of the local service provider (and so from the perspective of the intended beneficiary) are the obstacles and issues evident in programs that involve multiple agencies or centers of authority, even within the same service sector.

Conflicting concepts of purpose or treatment philosophy generate dissension and attenuate service. Although the debate in part reflects differences between liberal and conservative political factions, it also reflects important differences in notions of service and standards of effective service or quality. In Chapter 5, Grubb describes the longstanding debate between the state Department of Social Services and Department of Education in the area of child care, for example. The former frames the fundamental purpose of child care services as custodial; the latter assumes child care to be developmental. This elementary lack of agreement on general purpose has generated incapacitating suspicion and lack of cooperation between agencies at both state and local levels.

Further, authors of the preceding chapters point to contentious disagreement about purpose and philosophy even within a service area. In Chapter 11, Ventresca and David lay out the lines of debate and disagreement between those who believe juvenile justice programs should continue their dominant focus on rehabilitation and those who argue for dominance of a punishment objective.

Lack of communication among service providers also frustrates service provision. School staff are notoriously unaware of services available through juvenile justice, social service, or mental health agencies. Incompatible regulatory frameworks create additional obstacles. For example, a program for teenage parents sponsored by the Department of Social Services ran afoul of Department of Education regulations forbidding infants on school buses.

Even more fundamental to issues of implementation, the incentives for agencies or institutions to do other than move along in single-track service are nonexistent to negative. There is little or no money to encourage cooperation among agencies or agents. Consequently, efforts to integrate or coordinate are "above and beyond" the already crowded scope of youth service professionals' responsibilities.

Were these incentives available, they would naturally function as positive sources of encouragement, but they, too, would need to contend with the multiple *negative* incentives associated with cooperative or integrated efforts. The preceding chapters provide many examples of debates among service providers: Who gets the money which follows the child if services are shared? Whose treatment philosophy dominates? Who gets to decide about the standards, scope, and nature of programs or services for children in a joint agency setting? How are misaligned incentives to be reconciled? For example, it is crucial to the AFDC agency that district attorneys' offices vigorously pursue child support collection. However, despite intent or sympathies, child support collection figures low in the priorities of most district attorney staff and cannot compete with other more important (or more interesting) demands on the time of legal staff.

Isolation of professionals, agencies, and services is the inevitable result of a system that through its rules, regulations, incentives, and structure reifies and reinforces conceptions of discrete problem areas and bounded professional turf. Professionals in most areas are trained in separate university schools such as education, social work, and public health. They rarely come in contact with each other during their careers at professional meetings or informal networks. However, the consequences of such compartmentalization are much more than simply irritating and inefficient. They signal widening cracks in the system of children's resources, with increasingly serious implications for youth as more and more of California's young people require multiple services. Whose responsibility, for example, is the abused youngster who turns to prostitution?

A key problem has been not only the isolation of these services from each other, but also from school, the institution that society has traditionally relied on most heavily to prepare youngsters for a productive adulthood. Only a few schools in California, or elsewhere in the nation, have family counselors or health facilities available on school premises.[6] Instead, only principals as disciplinarians, or guidance counselors as test advisors and college catalogue librarians, are there to listen to children whose parents are substance dependent, violent to each other and their children, or beset by severe financial or medical difficulties. Adolescents who are often either surrogate parents to younger siblings or biological parents themselves are treated as "children" who have not yet reached the "age of responsibility." School authorities—as well as social service agency personnel—see their domains of concern as separable: the school wants to keep the teenager in school, while the social worker wants to ensure that the student's child is not neglected or abused.

But the absence of integrated, coordinated services for children is only one aspect of the problems apparent in the preceding reviews. The *conceptualization* underlying services in the various domains precludes construction of an adequate, vital system of children's resources. In particular, few if any services or resources for children take a longer-term developmental perspective, or see youth as more than temporary "recipients" with documented needs to be filled. Public agencies or private organizations are not oriented toward following the life course of a child who is in deep trouble and whose family is nonexistent to incapable.

What follows is a sampling of the 1988 interagency planning and joint service delivery efforts in existence or in the planning stage in San Francisco:[7]

1. The Balboa Teen Clinic
2. The Subacute Residential Treatment System for Children and Adolescents
3. The Cooling-Off House for children in placement
4. The San Francisco General Hospital Child Assessment Center
5. The Teenage Pregnancy and Parenting Project
6. The Interagency Case Management System
7. The Mental Health Interagency Planning Committee for Children and Youth
8. The After-School Action Plan Committee
9. Here's Looking at You 2000
10. The Mayor's Task Force on Dependent Children
11. Youth Emergency Services—AB 90 Status Offender Network
12. School Attendance Review Board
13. Project Stay-in-School

What is problematic about such projects is that special projects alone do not lead to larger systemic solutions. They require an inordinate amount of time and effort in an otherwise uncoordinated system and often cause problems of their own. Because they are usually funded through grants and foundation funding, they usually close down when the funding runs out, leaving both consumers and staff discouraged and scrambling to integrate themselves into other service systems.

Added to this fragmentation of approaches is the simple fact that few schools or services provide time or opportunity for youths to see demonstrated or to practice core competencies for dealing with either the work world or the bureaucratic maze of public services.

Adults in both schools and service agencies talk *at* youths, labeling their problems and fixing solutions dictated by administrative fiat or "that's just how it's done" procedures. Young people rarely have a chance to help identify the problem or to consider possible alternatives, weighing risks and benefits. Schools certainly offer precious few occasions for students to practice these competencies in either oral or written language; youth services follow the same denial of opportunity pattern, judging youngsters as incapable of separating fact from opinion or working through ways of handling recurring problems. Thus youth services personnel—as well as procedures and policies—offer and dictate a paternalistic approach to young people and argue that the "mess of their lives" indicates that they have no such capabilities. Most institutions that touch the lives of young people beyond their own families systematically deny them access to opportunities to participate meaningfully in what the business community has identified again and again as "core competencies" for success in employment.[8]

Conceptualizing the Problem and Responding Effectively

When examined closely, single-issue, isolated approaches rarely have anything more than temporary effects. It is necessary to look beyond narrow answers to broad sweeps of intervention and resource provision. Here we can look to the ways in which children and youth go about solving their own problems, to find a strong model of the many ways in which youth can help themselves. Children and youth in some communities have had to take the lead in asserting that socialization is not a passive process in which the young wait to receive the emotional commitment, skills, attitudes, and values of the elders who offer single solutions. The strongest children have found for themselves interactive situations in which they reach out for and take up activities in a wide-ranging and often unpredictable network of partial solutions to their problems. The Urban Education Center of Teachers College, Columbia University has shown that minority members who have "made it" into economic and personal success, though by all statistical predictions and demographic variables they should not have, did so because they sought out individuals or institutions that accepted them as active, capable decision makers.[9] And, crucially, these individuals provided the personal, ongoing support required to stabilize and nurture the accomplishments or skills associated with various special programs.

More than enhanced self-esteem is necessary to move youth and their families to a level of economic and social independence. A supportive environment, responsive to the multiple requirements of productive, healthy development provides essential context for any program effort.

There is no single uniform path for the unfolding of biological and neurological capability. Each sociocultural group has ways of promoting some capabilities and retarding others. Moreover, the learning of all individuals is recursive, moves in spurts and lags, and depends heavily on affective reinforcements that may come from peers, younger siblings, or adults. In addition, much learning comes through activities and interactions that depend on nonverbal communication, apprenticing, demonstration of activities, and jointly accomplished events that need not be verbally explicated or engineered by adults. Indeed, children who have not been held back and forced into the norms of a unilinear path of development often find their own resources, generally beyond the family and the school, in the community. As Chapter 7 by Miller and Orr indicates, neighborhood-based groups, such as churches, athletic clubs, or scouting, provide joint problem-solving opportunities that engage youngsters in activity-based socially interactive learning.

Institutions tend to treat problems as acute rather than chronic, as episodic rather than continuing, and do not regard themselves as learning environments that can involve children. Hence, services tend not to build on each other or acknowledge informal child-selected resources, because of the mechanistic approach that assumes a linear developmental path and adults as fixers of children's problems. For example, public and private services do not follow the life course of a vulnerable child who is born with serious medical problems and grows up in a disadvantaged home.

What Information Is Available?

The overwhelming majority of data reporting the effects of children's services comes from either agency personnel, from questionnaire surveys of clients or the general public, or from brief interviews. Reports prepared within agencies provide information for preordained "input" categories, in the most efficient statistical array, and without contextual data on exceptions, problems, or successes that don't fit the usual expectations. As Barth notes (Chapter 10 on children's protective services), agency information does not track a child over time and focuses on episodic "interventions" rather than on the universe of need in the community.

Survey methods of collecting data assume both (1) consistent levels of commitment to providing accurate information among respondents and also (2) uniform familiarity by all respondents with the discourse forms. Answering direct questions by choosing one among several preselected responses or taking part in an interview are normal methods used by most agency or survey personnel. Yet many individuals and numerous sociocultural groups do not share mainstream assumptions about direct questions asked either in written or interview forms. Moreover, nonliterates and non-native English speakers—those most often in need of services for children—are rarely included in such data collection efforts. Attempts to document the aggregate effects of several programs' procedures on children and their families are missing from evaluations or "measures" of the effectiveness of individual programs.

The data collected, inadequate as they are, rarely feed back into either reform or reflection by agency personnel. Most of the data focus on program "inputs" (dollars spent and categories of children served) rather than "outputs" (the resulting conditions of children and changes in their environments). Choices regarding types and extent of data collected, as well as methods of analyzing or assessing data, are predecided by the administration. Thus the collected information reifies the stability of institutions and constrains thinking about reforms that could be proactive and preventive, rather than reactive and prescriptive as now. Education is the only public service agency that does not operate in this information mode.

No developmental or long-term self-evaluative approach to agencies or services emerges from existing databases. Moreover, because data go primarily to either governmental funders or to agency staff, the data rarely receive objective critiques from outsiders, such as elected public officials or social scientists, who might be inclined to offer overarching views of what the data of a particular agency mean for change, deletion, or intensification of operation and self-assessment practices. The preceding chapters illustrate repeatedly how available data determine and perpetuate an underlying approach that sees children's services as fixing problems that families create or as attempting to make up for deficits that result from inadequacies elsewhere in children's lives.

Similarly, professionals at all levels within the agencies reported on here must find it impossible to focus on the interactive or interdependent nature of their contribution to the environment of the state's youth. Instead, they look only at their independent performance as members of particular agencies. Teachers, physicians, workers in the juvenile court system, social workers and child advocates, leaders of neighborhood-based organizations (from churches to Boy Scout troops), public recreational personnel, and librarians have devoted time and effort to children, but each piece of the picture shows only a small segment of the everyday experience of youth. How can questions be answered if someone is not looking at all the pieces, and eventually considering how the pieces fit together to create an environment of childhood that can help ensure an adult life of satisfactory personal relations and work productivity?

Research has barely begun to develop a broader frame of reference that could answer these questions or illuminate the aggregate effects of the totality of children's policies on youth and their families. There simply are no data on how the recipients or targets of California's byzantine children's services system experience existing policies and practices. Professionals such as teachers, nurses, and probation officers are prepared in segmented programs that rarely stress the interrelated nature of children's problems. The inadequate socialization and training of professionals often begins at the university, where interprofessional or coordinated professional programs are stymied by traditional departmental structures.

Rethinking Children's Services

The consequences of a system of children's services that are defined by administrative regulations and conceptions of "turf" as articulated in isolation by physicians, educators, judges, social workers, counselors, nutritionists, and other professionals are more than simply exasperating or inefficient. The system, many professionals and analysts agree, is beyond fixing with "a bit of this" improvement and "some of that" innovation. It is in need of fundamental rethinking.

This conclusion is not new. Neither is the prescription of "more integration," "more coordination," and "more collaboration." The state's own Little Hoover Commission expressed this view in 1987.[10] So, in 1981, did members of the Study Project on Children's Services, sponsored by the National Research Council's Committee on Child Development Research and Public Policy, examining the general state of children's services nationally.[11]

Yet most analyses stop with this plea. The problems of doing other than continuing current arrangements are admittedly formidable. The institutional structure of children's services, which is built on political compromise, time-honored professional terrain, and existing administrative arrangements intimidates efforts at reform. Such a structure poses fundamental obstacles to seriously considering a different model of children's service. The usual prescription encourages an earnest nod at the need for "more integration" or "new approaches," and counsels a return to existing practices for reasons of political, bureaucratic, and fiscal feasibility.

However, even in the face of such imposing difficulties, a number of promising responses to current problems are appearing in California and communities around the country. Pushed by a sense of urgency and a conviction that reconceptualization is demanded, practitioners and policymakers in many diverse arenas have moved to recast aspects of children's services both structurally and conceptually. Although they fall short of addressing dysfunctions in the system, and simply attempt more modest goals of making a particular domain of children's services work better, they can provide valuable and concrete responses to the problems we outline in this critique of California's practices.

Approaches to more effective children's services cluster in three areas: (1) making information available to policymakers and practitioners, (2) conceptualizing the problem and responding effectively, and (3) providing service. Our intent here is not to describe these efforts in detail or provide information based on extensive evaluations of their success. The objective is to point out projects and policy changes that move in the right direction.

Service Coordination

A number of communities provide illustrations of efforts developed to deal with the discontinuities of a fragmented service system and isolated professional staff. For example, both Ventura and San Bernardino have created coordinating mechanisms to provide more integrated services to clients. Ventura established an interagency network that includes cooperation at the highest administrative levels. Mental Health, Social Services, Corrections, and Special Education share responsibilities for the system. Formal agreements are signed by agency directors to reinforce the continuity of services. All services are based on written interagency agreements to treat a full range of problems that place a child at risk. With a specific focus on high-risk children who are either potentially or actually living out of their natural homes, the Ventura program reportedly has been successful in blending services and personnel from agencies participating in the network into a comprehensive and continuing treatment for troubled youth. Services follow the child, thereby establishing new links with private sector health care providers.

The San Bernardino program is modeled after Ventura's efforts, but has its own distinctive features. The San Bernardino Children's Network includes many agencies.[12] The Children's Policy Council engages the participation of all major youth-serving agencies in the county—juvenile justice, the schools, public health, community services, the district attorney, the sheriff, libraries, Head Start, probation, and others. The Children's Policy Council is served by a Children's Advocate Council whose goal is to provide advice and "grassroots" awareness of problems and community-based children's issues. Members include representatives from the PTA (Parent-Teacher Association); the United Way; the Foster Parent Advisory Committee; the Maternal, Child and Adolescent Health Advisory Board; and the drug advisory board; as well as a ministerial representative and a representative from the Native Americans group. A Children's Services Team provides the vehicle for ongoing monitoring and evaluation of program services; a First Fund of Children's Resources aims to form a partnership to bring together public, private for-profit, and private nonprofit sectors to provides monetary and in-kind contributions, goods, and services for children's services.

In both Ventura and San Bernardino, planning for an integrated service model was facilitated by special funding from state sources, and influential members of the community—a juvenile court judge, in both cases—pushed for change. Both efforts had high-level support from key agencies from the beginning, as well as a strong commitment of middle-level professional staff. However, legislation was not presented by the governor to expand these creative approaches to other counties through state funds. This could have provided a basis for comparative evaluation in different locations that could be used to judge effectiveness and implications for statewide policy.

Minneapolis also has a structure committed to coordinating a range of youth services.[13] Unlike the Ventura and San Bernardino efforts, which originated with and are sustained by youth service professionals, Minneapolis's Youth Coordinating Board (MYCB) is a creation of municipal government and the mayor. Created through a joint powers agreement between the City of Minneapolis, the Minneapolis Public Schools, Hennepin County, the Minneapolis Park and Recreation Board, and the Minneapolis Public Library Board, the eleven-member MYCB defines its goals in terms of promoting the integration and quality of services for all the community's young people, not just youth with special needs:

> Unique in its inter-governmental structure and focus on children, the MYCB is not intended to become a large bureaucratic agency, but rather a *catalyst* for comprehensive, collaborative planning and implementation of *integrated services* which promote the healthy development of all children within our community.

As in Ventura and San Bernardino, funds were made available for planning and operation of the coordinating body. Each of the five sponsoring governmental bodies contractually agreed to provide at least $100,000 per year for five years to support basic staffing and operating costs. The apparent success of the MYCB thus far is to a significant degree due to the mayor's vigorous commitment to integrating youth policy for the city and making its development a top municipal priority. Furthermore, the strategy for getting started and mobilizing broad community support was important to the MYCB's present level of operation. Plans and activities began with a well-regarded early childhood family education program that did not, in the words of the executive director, "isolate the poor or particular neighborhoods" but served all children from 0 to 5 years old with home visitors, child advocates, and other services. MYCB has created its own local property tax base that can provide revenue for integrated children's services.

The Ounce of Prevention Fund in Illinois, created in 1982 as a partnership between the state child welfare agency and a private philanthropic institution, serves as a broker and coordinator of services in a number of communities throughout the state. The Ounce of Prevention Fund supports a statewide system of service, research, training, and technical assistance focused on community-based programs for preteens, teen parents, and their families. Launched with matching grants of $400,000 each from the Illinois Department of Children and Family Services and the Pittway Corporation Charitable Foundation, other funders include an array of state agencies and private foundations as well as the National Center for Child Abuse and Neglect and the U.S. Department of Health and Human Services. The Fund can respond effectively to the regulatory tangles that impede interagency coordination because as a third-party organization it has more flexibility to blend services and activities. Also, because it is dedicated to brokering services and leveraging community-based support from a variety of sources (for example, churches, community action groups, corporations, the schools, and so on), it can enhance the resources available to the youth it serves. And, as a third-party intermediary, the Fund is free of suspicion of "special pleading," narrow institutional self-interest, or problem definitions rooted in professionally prescribed domains.

The Interagency Case Management System (ICMS) also focuses on the whole client, rather than only on the client's particular symptoms, in providing services.[14] For example, a single mother of a multiproblem family, recently discharged from a psychiatric hospital and in the middle of a panic attack, called her ICMS case manager. Whereas her Department of Social Services worker would likely have suggested she go immediately to psychiatric emergency services, her ICMS case manager helped the mother in her home so that her children would not be left alone.

Because case managers are familiar with all matters of consequence, they are better able to serve the family. The case manager's availability and familiarity with the family's situation are key factors. In addition, case managers' smaller caseload and broad scope of responsibility in relation to the family afford them the chance to make each crisis a potential teaching opportunity. Coaching individuals in how to identify their problems and on an appropriate course of action is a central tenet of the ICMS.

Ample research documents the multigenerational nature of family disorganization; that is, if you grow up in a disorganized, multiproblem family with passive, dependent, and discouraged parents, you are likely to develop an attitude of "learned helplessness" that will not prepare you to take charge of your own life and your family effectively. The ICMS is intervening in family dysfunction on several levels by supporting parents in their parenting roles and by teaching them how to act successfully on behalf of their families.

Although each of these efforts has pursued substantively different programmatic strategies, each also has self-consciously *reconceptualized* the purpose of youth services, moving from the traditional clinical and constricted notions that dominate most of the practices reviewed in this book to a developmentally-based view that sees the needs of youth as evolutionary and continuing. These approaches conceptualize youth services in the broader context in which youth live—family, school, neighborhood. For example, the Ounce of Prevention Fund frames central policy statements in terms of moving from activities based in a "pathology model" to services built from a developmental concept. The MYCB also features developmental language and stresses the need to engage a range of community resources in the promotion of productive adults. Although it is difficult (and perhaps too early) to tell the extent to which these reconceptualizations of the "problem" signal more than superficial or rhetorical change in policy, they nonetheless are prominent in self-reports, in service guidelines, and in goal statements. Only systematic evaluations over several years could tell us whether these approaches have been successful in meeting all their objectives.

Information and Evaluation

Few of the promising efforts just listed have acted to collect better and more comprehensive information about youth services and their consequences: who the youth are, what their needs are, what resources are available for them in the broader environment, what the aggregate effects of programs for youth and families are. Beyond "counting," even these reconceptualized efforts tend to rely on traditional evaluation or accounting models. Exceptions exist in Minneapolis and in the Ounce of Prevention Fund. An ambitious long-term planning effort associated with the MYCB, called "The City's Children: 2007," creates "Youth Action Committees" to "(1) set a vision for our community in twenty years and (2) formulate time-specific strategies to achieve the desired youth-development outcomes." As part of this comprehensive planning process, the committees will seek testimony from service providers, youth, their families, and other relevant parties. This activity, funded by the Emma B. Howe Memorial Foundation ($40,000), is one of the few efforts we encountered that attempted to reach out to the client community for information about needs, the effects of existing practice, and suggestions for the future.

The Ounce of Prevention Fund also goes beyond usual accounting and statistical compilations of numbers served, contact hours, and the like, to employ an independent evaluator to examine the various programs across the state and provide feedback to the sites "in order to strengthen services and define and describe program elements that other agencies can use." The Fund also supports research into "basic issues in prevention and early intervention." These evaluation and information-gathering activities are in large part a function of the third-party status of the fund and its relative freedom from the normal bureaucratic accounting procedures that consume data collection resources in public agencies.

Ventura provides an exception to this general statement. Ventura has invested in building an evaluation model that not only accounts within discrete service categories, but also attempts to examine program consequences across service areas:

> Past evaluation efforts concentrated on internal program measures... to assess outcomes. Evaluation did not address the client outcomes across all programs in a system of care. The Model provides external measures of the systems effectiveness and advocates for the use of measures of client outcome that follow the person across programs. . . . When fully developed, these methods will allow monitoring of system success by the State, and outcomes for clients across multiple agencies.[15]

Again, the availability of funding dedicated to planning and supporting the development of new practices, including evaluation, was essential to this "nonroutine" activity within the public sector.

Common Themes

These local efforts to restructure and reconceptualize youth services have a number of common features. First, they all had some outside funding. In particular, the important and facilitating role of private foundations emerged again and again in our conversations with individuals across the country. The "outside system" character of foundations is a particular asset in fostering innovative strategies within the system. The dollars provide essential organizational flexibility. State support for spreading such promising approaches could play the same catalytic role.

Second, we were struck by the "localness" of the programs we investigated. For example, while the "Ventura model" provides valuable guidance, communities adapt it to their own setting— as San Bernardino attests. The impetus for change came from different sources in different communities— the mayor's office, a juvenile judge, a school board member, or a local philanthropist, for example. What was similar once the initial spark had been lit was the engagement of relevant sources of power and authority in the community. Rules needed to be bent, incentives needed to be modified, energy needed to be mobilized. The active commitment of the people who had the authority to make these things happen in a community was indispensable to solving the problems of service and implementation outlined earlier.

Third, each community that appears to have made some progress toward a new model of service had two important assets: strong people at the middle level of the participating organizations and a history of trying to coordinate or foster integration. It is doubtful how much money could buy in the way of integrated services or new forms of collaboration if the will to do so were absent, or if no base of experience guided planning efforts. State funds to spread promising approaches must take these different local circumstances into account and not require a standardized model.

As impressive as these efforts are in the context of existing practices, however, they fall short of a long-term, comprehensive response to the needs of children. They try to make sense of a system that fundamentally doesn't make sense for today's youth. At the same time as strategies such as those discussed here can make the system work better, the longer-term view needs to be pushed simultaneously— a conception that proceeds from the broader view of who children are and of the environments in which they live and manage.

A Reconceptualization

Long-term approaches have to be marked by at least three features: diversity, competence, and comprehensiveness. To make integration work— to create a *community of resources*— these features must be acknowledged and acted on.[16] Community for individual youth becomes not a geographical space or a specific group of people, but an array of interactions and activities. These create occasions for joint sharing of norms, commitments to tasks, ways of using time, habits of displaying or sharing knowledge, and building a sense of self traversing from present to a hypothesized future. Community then becomes constructed within the individual through the shared and learned norms, behaviors, and beliefs that emerge from exposure to and experience within numerous activities. Participation is the key to the building of community, for participation offers opportunities to observe, internalize, listen, try, and talk about activities of the moment and their relationship to the future. It will not do much good to talk of integrating services for children unless we integrate children as active participants into the community of services and resources. It is not integration if we simply move to integrate services that continue to talk *at* rather than *with* children, or that continue to do *to* and *for* children rather than plan and work *with* them and their identified areas of support. Agencies cannot continue to assume that external agents have to be responsible for children because they cannot be responsible themselves.

Under current patterns of effective institutional commitment to children, and even within projected ideals of "integrated services," families, schools, health agencies, and other children's services view themselves as "giving" services to children. Youths are the recipients of nurturing, teaching, treatments, and remedies that institutions around them pass out. This view focuses on the child as individual in a world where caregivers (always adults) protect against and mitigate the forces of the outside world that might harm or work against the child's interests. Yet in reality, these institutions of protection– ranging from the family and the school to youth authorities– are often the actual agents of harm, against which only the strongest or most resourceful of the young can protect themselves.

Diversity, in both the ways that institutions respond to children and ways children can interact with institutions, must mark long-term planning for integrated children's services. Diversity thus operates in two ways– at one level through the combination of agents and organizations available to youth, and at another level in the array of ethnic, linguistic, and socioeconomic groups that respond to these agents and organizations in different ways as a result of cultural values, behavioral norms, language habits, and available resources. Differences among these groups lie not only in socioeconomic resources, but also in cultural habits of family interaction, norms regarding work and leisure time, and so on. Especially important are the ways in which families promote or allow their children access to community resources. For example, urban black families are more inclined to encourage their children to find work and leisure resources beyond the family than are recently arrived Mexican families. Single-parent middle-class families who have chosen "voluntary poverty" are much more likely to enable their children to take advantage of an array of free public services than are single-parent households who did not choose poverty.

Competence is the second goal that must guide long-term solutions. Here we mean creating institutions and institutional tasks that ensure competency for children. The California Conservation Corps, as well as other agencies that involve youths in tasks, group support systems, and long-term commitment, offer one such approach. However, even more traditional kinds of institutional organizations can find ways to promote children's competencies. Social service agencies that have their workers consult the child about school activities, after-school organizations, and leisure time usage give children opportunities for accountability.

Comprehensiveness comes in creating channels of communication, using the child as a prime transmitter of information. Currently social workers observe and talk with adults as the primary sources of knowledge about children. But, children themselves can become far more involved as sources of information. Rearranging institutions to facilitate the easy flow of information must build on a reconceptualization of the child's role. Teenage parents– as both children and students, on the one hand, and parents and wage-earners, on the other– now confront divided approaches to their needs. In the future, they must themselves take some responsibility for identifying their needs and for presenting themselves as trusted respondents and assessors.

What Is Next?

What is needed to get from what we have to what we need for children? This longer-range perspective requires support from research and evaluation that presently is missing. Because children's needs are not neatly compartmentalized, and because a consequential part of the policy debate cuts across categories, labels, and professional domains, it is essential that a considerable amount of research on youth and youth resources not be bound by existing institutional arrangements or authorization, but advance from a fuller view of children and their environment. Research bound to compartementalized definitions of the problem and associated policy solutions only perpetuates the dysfunctional fragmentation described in this book.

This longer-range perspective also requires a shift in the conceptions, myths, values, and assumptions that characterize present youth services and policies. Integration *qua* integration is only a partial response to the dysfunctions evident in present practice. Integration based in a notion of a new whole is fundamental to rethinking children's resources. Consequently, more effective youth policies pose a particular policy problem. Policymakers cannot mandate what matters most—changed conceptions and beliefs. Thus the policy problem is not only (or even) to codify, regulate, or require, but to persuade. This requires, at a minimum, more effective advocates for children *throughout* the policy system. In the short range, these advocates should focus on underservice in such areas as child abuse and health. In the long run, their goal should be to overhaul our current policy approach.

Chapter 14

State Policymaking for Children

By Claire Smrekar

California faces an array of challenges in its effort to improve the condition of children. These challenges are multiple and complex, and are complicated by recent profound changes in family structure, employment opportunities, income distribution, immigration, and ethnicity. Although state government cannot address these challenges by itself, nor be responsible for all interventions, the state does play a crucial role in setting policy regarding children. The state provides the bulk of financing for local governments and establishes minimum standards of care.[1]

This chapter explores the origins of state policy regarding children in California and traces the state's efforts from the early categorical programs of the 1960s to the reform efforts of the last decade and the current renewed interest in supercoordinating agencies and program czars. Structural and organizational approaches adopted by other states in their efforts to improve policymaking for children are surveyed. The portrait that emerges shows that competing, often contradictory, interests are buffeted by agency rivalry and battles over scarce resources. Analysis suggests that structural tinkering without a comprehensive examination of children's lives yields little beyond bureaucratic reshuffling. This chapter describes the current organization of children's services, highlights previously proposed reform initiatives, and examines various state approaches aimed at better serving the needs of children and youth. As California policymakers look ahead with the goal of improving the lives of children, this report offers a glimpse at policy directions both sound and simplistic.

The children's service delivery system in California has been assailed for decades as fragmented, inefficient, and ill-conceived. A series of reports, hearings, and commissions have examined the condition of children's services and recommended an array of organizational, procedural, legal, and legislative remedies. The following data provide a rough sketch of the current delivery system for child and youth services in California. The figures were compiled ten years ago by the Office of the Auditor General, and are the only statistics available that attempt to capture the scope of children's services.[2] Such persistent data gaps plague efforts to set policy on children in the state and hinder efforts to construct a coordinated delivery system.

- Approximately 160 programs serve children and youth in California.
- State programs are run by thirty-seven state units.
- State units are located in seven departments: Education, Social Services, Health Services, Developmental Services, Mental Health, Youth Authority, and Employment Development.
- Eligibility for these programs is determined by twenty-five separate categories of information related to financial tests, diagnostic conditions, and specific target populations.
- Services are delivered by twenty types of agencies at the local level.
- Services provided include education, child care, delinquency prevention, drug and alcohol abuse prevention, recreation, diagnostic and screening services, counseling, and information and referral.
- In one area—child care—twelve state entities report responsibility for services.
- At least six units report responsibility for services to physically handicapped, abused or neglected, and delinquent children and youth.
- Forty-two state plans deal with children and youth.

It is widely observed that state agencies in California often serve the same population of children and youth through multiple, overlapping systems. The impact of this fragmented structure on the quality of services delivered provokes competing and controversial interpretations. Critics charge that the current delivery system results in crucial service gaps, inefficiency, and waste. They describe an uneven and inconsistent system in which some counties provide an array of comprehensive services to children and youth, while other, often neighboring, counties deliver only limited services. Some observers, however, suggest that the loose organizational structure provides the flexibility and overlap necessary to ensure adequate and appropriate response within the county-administered system. In sum, there is relative consensus on the high degree of fragmentation within the system serving children and youth. Various conceptions of what an appropriate organizational response should be form the competing interpretations of this system's structural condition and its impact on the lives of children and youth in California.

Forces Shaping California's Current Delivery System

Viewed within the larger sociopolitical context, children's policy has evolved in response to a series of explosive periods in social welfare policy over the past several decades. Roles and responsibilities shifting among federal, state, and local government units have dramatically changed the authority, control, and accountability structures associated with children's services. The following section describes some of these conditions and their influence on service conception and delivery.

The most recent growth in children's services was triggered by the Johnson administration's Great Society programs in the 1960s. During this period, California responded to the availability of categorical funds by developing targeted services for vulnerable children and their families. Child health programs, child welfare programs, protective services, alcohol and drug abuse programs, mental health services, compensatory education, and a myriad of other categorical programs were implemented.

It is widely acknowledged that this period of explosive growth in children's services was conducted with little view toward developing a coherent children's policy and little clear conception of childhood. Discussion regarding the appropriate role of the state in the private lives of children and families was largely absent in hearing testimony and bill language. Abstract and sentimental appeals for adequate care, nourishment, and protection of children dominated the discourse between lawmakers, bureaucrats, and interest groups. Consequently, programs were enacted incrementally, with little attention paid to their interaction or collective impact. Each program responded to a single, identifiable problem, and maintained specific eligibility requirements and accountability mechanisms. Organizational structures—departments, bureaus, agencies— mirrored the diversity and range of programs. Each office was equipped with its own mandate and jurisdiction over distinct programs. In California, this period of programmatic growth gave birth to such superagencies as the Health and Welfare Agency and its multiple departments.

The 1980s ushered in a new era of consolidation and realignment. Under the Reagan administration, major categorical programs serving children were collapsed into a single package of available services, a block grant. The most significant revisions in children's policy were made in OBRA, the Omnibus Budget Reconciliation Act (PL 97-35), which Congress passed in 1981 as part of the administration's economic recovery program. This bill consolidated a range of programs and services for children in the Social Services Block Grant, the Community Services Block Grant, and the Maternal and Child Health Block Grant. Fundamental shifts in decision making, governance, and accountability accompanied these sweeping programmatic changes. With federal regulatory and fiscal influence reduced, the state role assumed new prominence in terms of both funding and delivering children's services. California lawmakers and interest groups responded by pursuing an active role in creating programs, setting performance standards, and providing guidelines for agency actions and decisions. The profound needs and special circumstances that embrace children present a unique challenge to interested policy makers, providers, academics, and interest groups. Their responses will necessarily be shaped by the following enduring influences on children's policy—federal policy, state politics, and the child advocacy community.

Federal Policy

Federal requirements for delivery of services to children and youth often serve to restrict the ability of state agencies to organize funding, delivery, and accountability of services in a consistent and efficient fashion. These requirements directly or indirectly cause fragmentation and overlap in the administration of services, and limit state agencies' abilities to promote integrated services at the local level.

The fragmentation that exists at the state level is magnified on the federal level. Individual agencies plan and administer a variety of federal programs with no overarching conception of children's lives or children's policy. Lack of interagency cooperation and integration exacerbates the situation for the state, which must respond to the myriad federal requests for eligibility, assessment, and evaluation information. In addition, issues of self-interest in responsible state and local agencies are also salient among federal officials, and impede efforts to identify service gaps and duplication. Turf problems throughout the vertical layers of government discourage agencies from exploring coordination and integration for fear they may lose programs, funding, organizational legitimacy, and status.

The Reagan administration's celebrated campaign for New Federalism, it was thought by supporters, could ameliorate some of these persistent bureaucratic ills. But despite the shift to block grants and the promise of greater local control and flexibility, state administrators are critical of regulations issued by the Office of Management and Budget that restrict discretionary action in the delivery of human services, including children's services. California officials report that, even when cost savings can be demonstrated, it is extremely difficult to obtain federal waivers of program requirements. Often such waivers would yield more efficient, simplified state administration.

Recently, the administration introduced the Youth: 2000 Initiative as a long-term strategic effort to improve the future for the nation's at-risk youth by the turn of the century. This initiative involves the Departments of Labor and Health and Human Services—the superdepartments charged with the bulk of children's services. While Youth: 2000 has produced public information materials and contributed to broader awareness of the issues central to children's lives, the effort appears threatened by management shifts internal to the Departments of Labor and Health and Human Services, as well as by the administration's interest in pursuing welfare reform before the close of the legislative term.

State Politics

Despite impassioned rhetoric and vaunted claims to the contrary, it appears that California state leadership in children's policy is either fragmented by members' special projects, nonexistent, or both. A careful review of legislative bodies reveals that programs are scattered over numerous legislative and nonlegislative committees charged with authorizing, funding, or investigating policies related to children and youth. These include (1) the Assembly Ways and Means Committee , Subcommittee on Health and Welfare, (2) the Assembly and Senate Committees on Human Services, (3) the Assembly and Senate Committees on Education, (4) the Assembly Select Committee on Child Abuse, (5) the Assembly Select Committee on Child Care, (6) the Senate Select Committee on Family Equity, (7) the Senate Select Committee on Children and Youth, and (8) the Senate Select Committee on Infant Child Care and Development. At the executive level the Department of Finance, the Office of Planning and Research, and the Office of Statewide Health Planning and Development are involved in reviewing various aspects of children's policy, but lack the resources and influence needed to implement planning and coordination activities. The current governor of California has not made children's policy an explicit priority of his administration.

The Child Advocacy Community

The child advocacy community is splintered into groups concerned with special interests such as child abuse, child care, and child welfare. These interest groups also represent different constituencies—parents, professionals, and providers—which often support vastly different and conflicting agendas. Many child advocacy groups lack the resources needed to support an effective lobbying organization. Consequently, no vigorous, politically potent voice for children and youth in California informs public policy in a consistent and coherent manner. This situation has sparked renewed interest in forming organizations specifically designed to join together fragmented special interests.

Proposals for New Governmental Structures

Since the early 1970s, California has conducted regular and systematic reviews of the condition of children's policies and programs in the state. The following is a brief historical sketch of organizational structures proposed in a variety of major reports over the past two decades.[3] Most represent relatively modest efforts to achieve greater organization control, coordination, and efficiency in the delivery of children's services. None of the recommendations involves a sweeping, substantive exploration of the ways in which children's needs are perceived and defined, and there has been little discourse or debate on restructuring the county-administered system. The organizational bias reflects a top-down, rational, and systematic approach to both conceptualizing and constructing a children's policy in California.

The Master Plan for Children and Youth

The Master Plan for Children and Youth was conceived as the blueprint necessary to force a stubborn state government bureaucracy to reorganize its children's services delivery system. Legislation was enacted in 1977 requiring the Office of Statewide Health Planning and Development to draft a Master Plan to be released by July 1, 1980. (The office later received an extension to January 1, 1981.) Briefly, the Master Plan was to include (1) a description of services and programs being provided to children and youth by public and private agencies, (2) a listing of potential public and private funding sources for development and expansion of these services, (3) a proposal for establishing within the Health and Welfare Agency a state Department of Services to Children and Youth, and (4) a study of the feasibility of establishing such a department.

Most observers acknowledge that the Master Plan was undermined by forces—public and private, state and local—that anticipated findings and recommendations detrimental to those forces' interests. The three-year project period provided time for opposition forces to coordinate their assault on the plan. The politicization of children's policy was evidenced halfway through this period when the Office of Statewide Health Planning attempted to placate polarized factions by including two proposals—one calling for the complete overhaul of the delivery system and the other recommending minor adjustments to the existing structure. After eight public meetings, two interim reports, and fourteen follow-up hearings, the Master Plan suffered a quiet death.

The Department of Children's Services

The Master Plan for Children and Youth included a proposal to establish a Department of Children's Services. A similar recommendation was included in the 1975 report *Growing Up in the Seventies*, by the Assembly Office of Research 1975.[4] The report concluded that there was little support for department reorganization, and that issues of self-interest among agencies with responsibility for children's services impeded any efforts to consolidate or realign services. A report by the Assembly Office of Research, *Realigning State and County Responsibilities*,[5] and

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subsequent legislation introduced by Assemblyman Sam Farr in 1982, recommended a modified Department of Children's Services housed in the giant Health and Welfare agency. This department would have succeeded the Department of Public Social Services in administering services to children in foster care, children requiring residential or day treatment, and children who were abused or neglected, including delinquent and status offender children as well as educationally handicapped children. The Farr bills would have established the Children's Service Fund to receive all money from state, federal, and other sources supporting services outlined earlier, thereby providing a single source of funding. The bills also would have directed each county to establish a children's services program to administer services. In addition, this legislation would have established an Interdepartmental Council on Children and Youth, chaired by the director of the state Department of Children's Services, and including the directors of each department within the Health and Welfare agency, the Department of Education, and other departments with responsibility for the delivery of services to children and youth. The Farr bills failed to ignite support, and died with the end of the legislative session.

The Children's Budget

The now-defunct Master Plan for Children and Youth also called for a state budget for children and youth. The plan suggested that a children's budget would build in efficiency and accountability and would (1) identify the programs and funds that support services to children, (2) encourage a closer relationship between budgeting and planning, (3) increase the state's capacity to make decisions regarding children's services, (4) facilitate cross-agency comparisons and planning, (5) identify gaps in services, and (6) identify budget areas in which the use of federal funds could be increased. This budget died with the Master Plan.

The Commission on Children and Youth

The Commission on California State Government Organization and Economy, better known as the The Little Hoover Commission, issued a report in October 1987 on the provision of children's services in the state. The commission focused its study on three major groups of children: (1) homeless children, (2) high-risk children—including sexually abused, physically abused, and neglected children, as well as pregnant teens, teenage alcoholics, and substance abusers, and (3) children in need of child care services.

During Phase I of the commission's study, major areas of concern were identified through public hearings, site visits, interviews, and consultations with service providers, community service representatives, academics, and policymakers. A preliminary report documented the scope and magnitude of the difficulties in the state's delivery of children's services. Phase II followed with specific recommendations to the governor and the legislature for improved planning, budgeting, and delivery of children's services.

The commission's final report recommended the creation of a Commission on Children and Youth.[8] Its mission would be to (1) act as an advocate for policy development and implementation of children's services, (2) enhance the coordination of children's services among state, local, and private agencies and service providers, (3) provide fiscal review and service analysis for children's programs, including the identification of ways to better use existing resources, and (4) propose legislative action to improve the provision of children's services. (In 1980 the proposed Master Plan included a recommendation to create a similar commission.) The bipartisan commission would consist of thirteen members:

- Five members appointed from the private sector by the governor
- One member appointed from the private sector by the attorney general

- One member appointed from the private sector by the superintendent of public instruction
- One member appointed from the private sector by the speaker of the Assembly
- One member appointed from the private sector by the Senate Rules Committee
- Four legislative members including:

    - Chairman of the Senate Appropriations Committee
    - Member of the Senate appointed by the Senate Rules Committee
    - Chairman of the Assembly Ways and Means Committee
    - Member of the Assembly appointed by the Assembly Speaker.

Although the commission would technically be a part of the executive branch of state government, it would function independently as an overseer committee and would report to the governor, the attorney general, the superintendent of public instruction, and the legislature.

Alternatively, the commission suggested appointing a "Children's Czar" to oversee and direct services for children and youth. Specifically, the czar would be responsible for developing a consistent state policy for children to be implemented by the appropriate state agencies and would oversee an interagency task force of department directors responsible for administering programs for children and youth.

State Approaches Aimed at Integrating and Coordinating Children's Services

Many state organizations embody aspects of the movement toward integration and coordination of children's services.

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State Commissions on Children

In recent years, several states have established commissions on children and youth in an effort to create a greater degree of organizational coordination and integration of services across state agencies and departments responsible for children. At present, thirty-three states have a board, commission, council, institute, or office on children. These organizations vary considerably in institutional history, structure, authority, statutory power, and mandate.

Most state commissions were created after 1980, particularly during the period 1983–1986. The state commissions were created in response to a variety of perceived needs, interests, and concerns. The majority were established in response to the governor's or legislature's interest in better coordinating children's services. Many of the commissions function as the organizational home for newly elected governors who have made children's issues a state priority. Some commissions, however, were created in response to concern about a single issue, such as juvenile justice. Other commissions were born of legal threat or embarrassment. One state commission was created to defuse a state class-action suit against the department of rehabilitative services. Another was prompted by a series of articles by a major city newspaper exposing disarray in the delivery of children's services.

In order to coordinate and integrate activities at the state level, formal channels of communication are established among agency directors responsible for delivering services to children. Regularly scheduled meetings with officials who would otherwise not speak to each other provide a forum for establishing cooperative agreements and exploring alternative program arrangements. Commission directors report that issues of self-interest and distrust hinder support for commission efforts initially, but the governor's influence and interest in providing cost-effective quality care plus the credibility of the commission itself create an atmosphere of cooperation and commitment.

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The recent increase in state commissions on children reflects a strong interest by legislators and governors in expressing a concern for children and youth both symbolically and substantively. Some states have structured their commissions to affect children's policy, planning, and administration; others have created a more modest research and advisory organization. In general, the state commissions have been established around three central goals: (1) to create a process that establishes communication between departments with responsibility for children's services, (2) to create awareness of children's needs and communicate those needs to policymakers, advocates, and the general public, and (3) to collect data on the condition of children and the state systems that serve them. The varying structures reflect the political, geographical, and historical conditions of the individual states, and are tempered by the influence of leaders in the legislature, administration, and bureaucracy. The idiosyncratic nature of this coordination mechanism and its lack of systematic evaluations make it difficult to judge the effectiveness of these models. Nevertheless, interest in creating a state executive agency on children seems likely to continue unabated.

Legislative Committees

In recent years, an increasing number of state legislatures have created special committees specifically designed to address child and youth issues. Standing committees on children and youth are designed to reduce fragmentation by creating one legislative structure responsible for most, if not all, child and youth issues. Select or special committees are temporary panels assigned specific issues, such as day care, child abuse, or teen pregnancy. These short-term committees are typically nonlegislative, and serve as "study groups" to research a specific social issue, hold public hearings on that issue, develop reports, and make legislative and administrative recommendations. (Some state legislatures prefer to empanel task forces or advisory councils, appointing both public and private members.)

According to a 1987 survey by the National Conference of State Legislatures, there are currently twenty-two state committees on children, youth, and families. The majority of these were formed during the last five legislative sessions. The type, life, and size of committees vary.

The growth of legislative or special committees on children and youth may reflect increased interest in and concern for improving policy for children on the part of state legislators. The creation of these committees bestows a certain degree of legitimacy on issues affecting children's lives, and can contribute to a more substantive, coherent dialogue between the child advocacy community and policymakers. Nevertheless, the relative power of these committees should be measured against the established authority and control of long-standing, traditional committees of power—Finance, Ways and Means, Human Services, and Education.

In many state legislatures, the committees on children and youth are chaired by newly elected, female legislators who have expressed a strong interest in children's policy. These committees' activities, given the chairs' modest legislative experience and few political "friends," may be limited to receiving public testimony and conducting small studies on specific, narrow issues. Thus, rather than serving as a focal point for legislative action, these committees may distract from more sustained, well-formulated legislative efforts.

Children's Budgets

Children's budgets are a reflection of state efforts to extract from all state agencies and departments a detailed fiscal analysis of programs and services for children. By tracing funding streams and reorganizing department budgets, states such as New York (in 1980) have attempted to improve planning, budgeting, and coordination in the delivery of services for children. The concept, however, sometimes proves troublesome in execution. State legislatures have found it difficult to disentangle multiple, overlapping programs and systems in their effort to provide an accurate and comprehensive portrait of children's services.

Children's Codes

Some states have limited their legislative remedies to a children's code, one that establishes a bill of rights for children in terms of a standard of care and range of services. Children's codes often reflect the states' interest in establishing a criminal code unique to children and youth and in reorganizing the juvenile justice system. More often, however, efforts to codify the rights of children and the state's obligations in responding to children's needs reflect symbolic, rather than substantive, responses. A number of state legislatures are currently considering a children's code or children's act to legislatively reorganize programs and services.

Traditional Approaches

Despite the flurry of programmatic initiatives and new organizations during this decade, most states continue to organize and deliver children's services through the traditional executive agency arrangement. At both state and local levels of government, the bureaucratic structure persists in an array of eligibility requirements, procedures, standards, categories, assessment tools, and treatment protocols. Perhaps in response to entrenched interests, and in the absence of other viable alternatives or broader conceptions of children's policy, several states and localities (including California) have adopted approaches aimed at improving communication, coordination, and integration of services within existing bureaucratic arrangements. Such approaches include interagency agreements, legislative mandates, interdepartmental coordinating bodies, task forces, and formal advisory groups.

Interagency Cooperation

Interagency agreements are made among executive agencies responsible for delivery of services to children and youth. These agreements may be either entered into voluntarily by departments or mandated by the legislature, and may apply to local entities as well as state agencies. Two principal types of interagency agreements coordinate children's services: (1) financial contracts and (2) designations of individual agency responsibilities in coordinated activity. In California, the Departments of Social Services and Education engage in financial interagency agreements regarding child care funds under the Social Services Block Grant. Nonfinancial agreements are typically used to comply with mandates contained in federal or state law. The federal Education for All Handicapped Children Act requires that the Department of Education establish agreements with other agencies providing services to handicapped children. Agreements mandated by state legislatures are considered more binding than internal ones, and usually carry more effective enforcement mechanisms.

Legislative Mandates

In 1984, landmark legislation introduced by Assembly Speaker Willie Brown clarified the legal responsibility for providing medically related services to handicapped children. Essentially, the legislation mandated interagency cooperation between mental health agencies and special education staff. Previous departmental interagency agreements had been ignored. Before the Brown legislation, bureaucratic chaos had resulted in local school districts assuming the fiscal and service responsibility for medically related services—tasks which the districts were ill-equipped to perform.

Another significant bill enacted during the 1984-85 legislative session focused on the need to improve coordination between several state agencies providing services to handicapped and high-risk infants. Assemblyman Louis Papan argued successfully that Assembly Bill 114 was necessary to eliminate confusion regarding conflicting mandates and eligibility criteria that differed from department to department, delays families experienced in attempting to locate services among several agencies, and duplication of administrative and assessment procedures. Notably, more sweeping recommendations to create local advisory councils and an interagency state commission were dropped after the Department of Developmental Services and the Health and Welfare Agency voiced their opposition to additional governmental structures. A move to create a lead state agency failed due to advocacy and provider-group reluctance to vest their interests in a new agency, one with which they did not already enjoy access and support. In the end, an existing task force assumed the responsibility to continue coordination activities.

Interdepartmental Bodies

Various interdepartmental bodies have been established in California during the past several years to better coordinate administrative functions across agencies serving children and youth. Examples include the Interdepartmental Council on Juvenile Delinquency Prevention and the Commission on Children's Services, which was created voluntarily within the giant Health and Welfare Agency. The commission develops a state strategy to support county efforts to coordinate children's services and establish priorities for annual program development efforts.

Task Forces

Many states, including California, have empaneled task forces to review current policies and make recommendations on specific children's issues, such as child care or child abuse. Often bipartisan and structured to include agency personnel, legislators, and private interest groups, task forces vary widely in the perceived level of leadership, legitimacy, and status. Consequently, some task force reports are instrumental in effecting change, while others are merely the artifacts of purely symbolic political gestures.

Advisory Groups

A number of state-level advisory groups have been mandated under federal and state law to exercise coordination responsibilities. These groups vary in composition, influence, and operation. Advisory groups may reflect the governor's desire to exercise control and influence over a specific issue, or may demonstrate policymakers' interest in responding symbolically to a politically volatile issue. Examples in California include the Governor's Advisory Committee on Child Development programs, the state Advisory Committee on Child Abuse, and the Advisory Commission on Youth.

Many states and localities have responded to the decentralized model of children's services by creating local bodies, including roundtables and advisory councils. In 1984, the Los Angeles County Roundtable on Children was established to review alternative arrangements for the conception and delivery of children's services. (The Los Angeles County Children's Commission, whose members include private citizens appointed by the board of supervisors, was established at about the same time.) Roundtable members include advocates, academics, community service representatives, government officials, and provider-group representatives. Their efforts produced one of the first comprehensive and instructive reports describing a large county-administered children's delivery system. The group is currently meeting with county supervisors and chief administration officers to begin implementing the report recommendations.

Two frequently cited examples of county coordination are the Ventura and San Bernardino County models. Ventura County established an interagency network that includes coordination among mental health, social services, corrections, and special education agencies. Formal agreements are signed by agency directors in an effort to reinforce the continuity of services. The Ventura model has reportedly been successful in blending services and personnel from agencies participating in the network and in structuring services to follow the child, even when the child leaves the immediate area. The San Bernardino model expands this arrangement by engaging all major youth-serving agencies in the county—juvenile justice, schools, public health, community services, district attorney, sheriff, libraries, and others—to serve on the Children's Policy Council. The Policy Council is served by the Children's Advocate Council, which includes members of relevant community service organizations. In both Ventura and San Bernardino Counties, planning for an integrated service model was supported by funding from the state, and facilitated by influential members of the community. Both programs received a high degree of support and cooperation from key agency personnel. Nevertheless, although these models retain legislative authority, state funding to replicate these models was eliminated from the 1989 California budget.

Looking Ahead

California is facing an array of challenging decisions concerning the way in which we serve the needs of children and youth. The state will need to consider adopting a comprehensive children's policy where only a collection of isolated, narrowly conceived programs exist today.

A children's policy can evolve out of a process that takes into account the complexities of childhood and the ambiguous relationship between family and state. A children's policy can be grounded in a broader conception of children's lives, one which is sensitive to the interests and traditions of different cultural, ethnic, and religious groups. A children's policy that reflects these ideals can emerge from a process that sanctions disarray and encourages vigorous and inspired debate.

While we are engaged in these considerations, it is vital to acknowledge the role of child-serving professionals—the individuals whose occupations are shaped at least as much by the organizations in which they serve as by the children and families to whom they deliver services. For example, professionals prepared to address nagging childhood pathologies or to provide educational and recreational services function in highly specialized, routinized environments. In general, a profound sense of mission and professional ethic exists among child-serving professionals. These professions are necessarily steeped in sentimentalism and caring. But a corresponding awareness of the enormous challenges before them threatens to dampen this exuberant spirit. Nevertheless, by fostering the cooperation of child-serving professionals across such fields as education, health, and social work, the process of crafting a children's policy for California can move toward a productive and ultimately more satisfying goal.

Chapter 1

[1] Louis Harris and Associates, *Children's Needs and Public Responsibilities: A Survey of American Attitudes About the Problems and Prospects of American Children* (1986).

[2] *Children in Need, A Statement by the Research and Policy Committee of the Committee for Economic Development* (1987).

[3] New York State Council on Children and Families, *State of the Child in New York State* (1988).

[4] T. Lash and H. Sigal, *State of the Child: New York City* (1976); M. Testa and F. Wulczyn, *The State of the Child Volume 1* (1980); M. Testa and E. Lawlor, *The State of the Child 1988* (New York State Council on Children and Families).

[5] Task Force on "State of the Child" Report, *Report to the Board Foundation for Child Development* (1974).

[6] Nicholas Zill, quoted in O. Brim, Jr., "Childhood Social Indicators: Monitoring the Ecology of Development," *Proceedings of the American Philosophical Society* 119 (1975).

[7] Ibid.

Chapter 2

[1] In this and subsequent chapters, we refer to children and the child population. In fact, our data refer to children and young people under 18 years of age. Much of the discussion in these chapters focuses on children and young teens; hence, we refer to children, meaning no derogation of the near-adult status of older teenagers. As we discuss in the chapter on children and the law, legal minority continues up to age 18, although the experiences of adulthood come earlier for many young people and later for others.

[2] In this chapter and the remainder of the report, we follow U.S. Census usage of the categories of race and ethnicity. These include three categories of race: white, black, and "other," with other including people of Asian, Pacific Islander (including Filipino), American Indian, Eskimo, Aleut, and other descent. Hispanics are people who self-identify as being of certain ethnic group origins from throughout the Americas and the Caribbean, including Mexican, Cuban, Central or Latin American, Puerto Rican, and others. Hispanics may be of any race; the majority of Hispanics in California are categorized as "white" in Census racial classifications.

Our usage, then, includes:

- The term "nonminority" or "white" refers to all non-Hispanic whites.
- The term "black" refers to non-Hispanic blacks.
- The term "Hispanic" includes all Hispanics, regardless of race. The majority of Hispanics are categorized as white in Census racial classifications, with a small proportion categorized as black or other.
- The term "minority" includes blacks, Hispanics, and people of Asian, Pacific Islander, American Indian, Eskimo, and Aleut heritage.
- The term "nonblack minority" includes Hispanics and people of the Asian or American Indian group descent.

These categories are not entirely either racial or ethnic. Rather, they reflect current political and cultural concerns and conventions. It is important to note that each of the minority and majority populations, particularly the so-called Hispanic population, comprise several groups with distinct socioeconomic and demographic profiles.

[3] Throughout California's history, immigration has accounted for substantial population growth. California has always been a locus of international immigration, as well as substantial migration from other states, particularly in the post-World War II period and again in the 1970s.

[4] We do not provide any data on illegal immigrants in this report. Estimates indicate that there are 1.6 million undocumented immigrants in California, many of them children; moreover, a substantial number are under 25 years old and hence in their peak reproductive years.

[5] Larger baby boom cohorts and recent larger birth cohorts will all be aging to adulthood by the year 2000, and decreases in the child population are projected; hence the larger proportional growth in the adult population.

[6] Children of Asian and Pacific Islander descent comprise over 90 percent of this group.

[7] The most recent reliable data on the distribution of children across local jurisdictions come from the 1980 Census. We have supplemented these numbers, where possible, with more current data. Available evidence suggests that the large increases in the Hispanic and Asian populations will not change the general picture described here.

[8] Census definitions of "urban" are inclusive, such that over 90 percent of the population live in urban areas, defined as local jurisdictions of over

2,500 people. In this report we use more restrictive Census categories: "central city" and "urbanized areas."

Chapter 3

[1] Throughout this chapter, we have benefited from the discussion of children's family lives found in two reports – *The State of the Child: New York City* (1976) and *The State of the Child: New York State* (1988).

[2] For a good review of the impact of family interaction on children's development, see E. Maccoby and J. Martin, *Social Development* (1980).

[3] These factors are examined in most other "conditions of children" reports. Those reports do not generally specify why they have focused on these factors.

[4] Attention usually focuses on *mothers'* behavior or the consequences of single *motherhood*. The consequences of men's behavior are ignored. Because most children living in single-parent households live with their mothers, we also generally look at the impact of living with single mothers. It must be recognized, however, that fathers and mothers both have brought about the changes.

[5] The percentage of children who have siblings is greater than the percentage of families that have any given number of children. In 1985–1986, 21 percent of children were only children, 39 percent of children lived in families with two children, 22 percent lived in families with three children, and 18 percent lived in families with four or more children.

[6] California has a somewhat greater proportion of large families than the nation as a whole. This reflects the larger percentage of immigrant and first-generation families in California; these groups tend to have larger families. See Chapter 2.

[7] This percentage may vary from other reported statistics on the percentage of children in single-parent households. Some people report the number as a percentage of *all* children, regardless of whether they live in a household headed by a parent. Others calculate the percent based on the total number of children *living with a parent*. While the totals will be close, since most children live with at least one parent, the percentages will not be exactly the same. Approximately 8 percent of children live with adults other than their parents. For policy purposes, we are interested in both the children living with no parent and those living with single parents. Both the number of adults in the house and their relationship to the child can affect the child's well-being.

[8] This figures includes some children living with a single female householder not their mother (grandmother, aunt, or other woman) and is very slightly higher than the proportion on single-*mother* households. We are not able to obtain data for the years after 1980 on the percentage of children living with their mothers and with no spouse present. In 1980, however, over 90 percent of children living with single female householders were living with their mothers. Thus, between 18 and 19 percent of children live in single-mother households.

[9] In some single-parent households, whether headed by a mother or a father, there may be other adult relatives in the home, or the parent may be living with a companion.

[10] The proportion of black children living with two parents was 56 percent in 1970. Data for Hispanic children are not available for before 1980, the first time that the U.S. Census Bureau collected separate, reasonably accurate data for Hispanics. Moreover, national statistics regarding Hispanics cannot be adequately compared with California figures. The term *Hispanic* includes people of Central and South American, Cuban, Mexican, and Puerto Rican origin. For many behaviors of interest in this chapter (for example, divorce rates and nonmarital births), researchers have found systematic and substantial differences among these groups. Puerto Ricans and Cubans comprise a much larger percentage of the national Hispanic population than is the case in California, where Hispanics are predominantly of Mexican origin.

[11] Because researchers have based their estimates on different samples and used somewhat different methodologies for making estimates, there is no agreed-upon number. However, the various studies come to basically similar conclusions. See A. Cherlin and J. McCarthy, "Remarried Couple Households: Data from the June, 1980 Current Population Survey," *Journal of Marriage and the Family* 47:12 (1985); A. Norton and P. Glick, "One Parent Families: A Social and Economic Profile," *Family Relations* 35:9 (1986).

[12] L. Bumpass, "Children and Marital Disruption: A Replication and Update," *Demography* 21:71 (1984).

[13] S. Hofferth, "Updating Children's Life Course," *Journal of Marriage and Family* 47:93 (1985); Norton and Glick (1986).

[14] In addition to divorce, many parents also separate for periods of time. In most instances, this separation is a prelude to divorce. Other parents reunite. In some cases the parents remain permanently separated without divorcing. This is especially true with regard to black families. For convenience purposes, we treat long-term separations and divorce as the

same. There is no reason to believe the impact on children differs.

[15] C. W. Nord, "Children's Experiences with Divorce and Single Parent Families: An Update and an Extension," unpublished paper Washington, DC: Child Trends, Inc., 1987).

[16] Nationally, rates for black children are estimated to be approximately 50 percent; the figures for whites are approximately 35 percent, with a somewhat lower estimate for Hispanics. See Nord, 1987. Since California no longer includes racial and ethnic information in its divorce statistics as a result of legislative mandate, we cannot give estimates specific to California families.

[17] Parts of this section were written by Claire Brindis. In Chapter 8 Dr. Brindis discusses other aspects of teenage sexual activity, pregnancy, and childbearing, and describes programs designed to reduce the occurrence and negative effects of teenage motherhood.

[18] These figures, plus much of the other data in this section, are taken from C. Brindis and R. Jeremy, *Adolescent Pregnancy and Parenting in California—A Strategic Plan for Action* (1988).

[19] Ibid.

[20] See Chapter 4 for a breakdown of the relationship between family structure and economic status. The income of single fathers is considerably higher than that of single mothers, although it is lower than that of two-parent households. Very few single fathers live near or below the poverty level. Yet the problems experienced by children following divorce also are found in single-father families, indicating that income alone probably is not the sole factor causing the problems. Because single mothers' income is so low, however, economic factors may be dominant in many single-mother families.

[21] The literature on the impact of divorce is quite extensive. Several major studies have followed the development of children for a number of years following divorce. See, for example, J. Wallerstein and J. Kelly, *Surviving the Breakup* (1980); J. Wallerstein and S. Blakeslee, *Second Chances—Men, Women and Children a Decade After Divorce* (1989); E. M. Hetherington, M. Cox, and R. Cox, "Long-Term Effects of Divorce and Remarriage on the Adjustment of Children," *Journal of the Amerercan Academy of Child Psychiatry* 24 (1985). A good summary of the literature is R. Emery, *Marriage, Divorce and Children's Adjustment* (1988).

Although the studies are virtually unanimous in finding short-term pain and trauma for most children of divorce, the long-term impact is somewhat less clear. Wallerstein finds that many children experience emotional problems into adulthood. Other research has found that most children and adults adjust reasonably well.

One problem with virtually all the research is that it focuses only on white, predominantly middle-class children. We do not know whether the findings are equally applicable to Asian, black, Hispanic, or other children.

[22] N. Zill, "Divorce, Marital Happiness, and the Mental Health of Children: Findings from the FCD National Survey of Children," paper presented at the National Institute of Mental Health Workshop on Divorce and Children (1978).

[23] These findings were first reported by Hetherington. One recent study finds that the lessened monitoring persists for years after the divorce. See S. Dornbusch and others, "Single Parent, Extended Households and the Control of Adolescents," *Child Development* 56 (1985): 362. While the decline in income is a factor in the changed behavior, even those single parents with adequate income often act differently with their children.

[24] R. Emery (1988); S. McClanahan, "The Consequences of Single Parenthood for Subsequent Generations," *Focus* 11, no. 3:16 (1988).

[25] R. Emery.

[26] N. Zill, "Behavior, Achievement and Health Problems Among Children in Stepfamilies: Findings from a National Survey of Child Health," in E. M. Hetherington and S. Arasteh (eds.), *The Impact of Divorce, Single Parenting, and Step-Parenting on Children* (1988).

[27] Some evidence suggests, among children of single mothers, those who live with their grandmothers as well do better in terms of academic performance and social development. See S. Kellem, M. Ensminger, and R. Turner, "Family Structure and the Mental Health of Children," *Archives of General Psychiatry* 34:1012 (1977). It is not clear whether it is the presence of another adult, or the fact that those single mothers who live with their own mothers are different from other single mothers, that accounts for these differences.

[28] We base our discussion of teenage mothers and their children primarily on the work of Frank Furstenberg and J. Brooks-Gunn and that of Brindis and Jeremy. See J. Brooks-Gunn and F. Furstenberg, Jr., "The Children of Adolescent Mothers: Physical, Academic, and Psychological Outcomes," *Developmental Review* 6:224 (1986); F. Furstenberg, J. Brooks-Gunn, and S. Morgan, *Adolescent Mothers in Later Life* (1987); Brindis and Jeremy.(1988). The impact of pregnancy and childbearing on the young mother is also discussed in Chapter 8 of this volume.

[29] Although there is some evidence that a mother's youth, regardless of marital status, has a negative impact, we do not think there is enough

evidence to draw any firm conclusions about the relationship of married teenage parenthood to the condition of children.

[30] See Brindis and Jeremy (1988).

[31] Ibid.

[32] In general, low-birthweight or premature babies experience physical, developmental, and cognitive deficits. A number of studies have found that these deficits disappear over time, for the most part, among children from middle-class families, but they get worse among children from families of lower socioeconomic status. See, for example, E. E. Werner, J. M. Bierman, and F. E. French, *The Children of Kauai* (1971).

[33] J. J. Card, "Long-term Consequences for Children of Teenage Parents," *Demography* 18:137 (1981).

Chapter 4

[1] M. Hill and G. J. Duncan, "Parental Family Income and the Socioeconomic Attainment of Children," *Social Science Review* 16:39 (1987).

[2] W. Sewell and R. Hauser, *Education, Occupation and Earnings* (1975).

[3] These programs are described more fully in Chapter 12.

[4] The changing economic status of children and families, looked at nationally, is reviewed in V. Fuchs, "Why Are Children Poor?", National Bureau of Economic Research Working Paper No. 1984 (1986). The status of young families is analyzed in C. Johnson, A. Suhr, and J. Weill, *Vanishing Dreams: The Growing Economic Plight of America's Young Families* (1988).

[5] Fuchs (1986).

[6] Ibid.

[7] G. Duncan and W. Rodgers, "Longitudinal Aspects of Childhood Poverty," *Journal of Marriage and the Family* 50:1007 (1988).

[8] For a more comprehensive but somewhat more technical analysis of why children are poor, see Fuchs (1986).

[9] This figure was derived from the 1985 and 1986 Current Population Surveys.

[10] These changes are discussed in Chapter 3.

[11] Child support programs in California are discussed in Chapter 12.

[12] The income of these families is increased by food stamps and free medical care. Even counting food stamps, however, a family of three would have an income slightly below the poverty level.

[13] The relationship between lesser education and larger family size, a relatively recent phenomenon, holds true nationally. In California, the relationship may be stronger because of the higher percentage of immigrants in the population. Immigrants tend to have less education and larger families.

[14] This discussion is based on national data; no California data is available. The national data have been compiled in Johnson, Suhr, and Weill (1988). The situation in California should parallel the national situation with respect to this issue.

[15] Figures from Johnson, Suhr, and Weill (1988).

[16] Maine Department of Human Services, *Children's Deaths in Maine, 1976–80 Final Report* (1983).

[17] L. Egbuonu and B. Starfield, "Child Health and Social Status," *Pediatrics* 69:550 (1982).

[18] U.S. Department of Health and Human Services, *Study Findings—Study of National Incidence and Prevalence of Child Abuse and Neglect: 1988.*

[19] A. Hahn, J. Danzberger, and B. Lefkowitz, *Dropouts in America* (1987).

[20] J. Flanningan and W. Cooley, *Project Talent: One Year Follow-up Studies* (1986).

[21] F. Furstenberg and J. Brooks-Gunn, *Adolescent Mothers in Later Life* (1987).

[22] See also S. McClanahan, "Family Structure and the Reproduction of Poverty," *American Journal of Sociology* 90:876 (1985).

Chapter 5

[1] *Children in Need: Investment Strategies for the Educationally Disadvantaged* (New York: Committee on Economic Development, 1987).

[2] The Gallup Organization, *California Child Care Final Report*, (1985).

[3] These figures are derived by applying the proportions of children in care from Table 5-2 to figures on the numbers of children in different age groups from the Current Population Survey, and averaging the 1985 and 1986 years; these figures, developed by PACE, are reported in Chapter 2 of this book. The only other population figures available are the forecasts of the California Department of Finance, which are not far from the PACE figures. Note that these estimates of the numbers of children in care are substantially lower than the numbers of children who are prime candidates for child care reported in Table 5-1. This confirms once again that even many parents who work full time manage to find arrangements for their children that do not involve paid child care.

[4] How enduring these differences are is unclear. Extended kin networks appear to be most prevalent among first-generation Hispanic immigrants,

and appear to dissipate by the third generation.

[5] Laura Lein, "Parental Evaluation of Child Care Alternatives," *Urban and Social Change Review* 12 (Winter 1979).

[6] J. Berruata-Clement, L. Schweinhart, W. Barnett, and A. Epstein, *Changed Lives: The Effects of the Perry Preschool Program on Youths Through Age 19*, Monographs of the High/Scope Educational Research Foundation (Ypsilanti, MI: The High/Scope Press, 1984).

[7] National Day Care Study, Volume 2. *Children at the Center*. (Cambridge, MA: Abt Associates, December 1978). Many of the preschool programs recently enacted by states incorporate ratios of 1:10, and NAEYC has recommended a ratio for 1:10 for 3- and 4-year-olds.

[8] For information on salaries, see W. Norton Grubb, *Young Children Face the States: Issues and Options for Early Childhood Programs* (New Brunswick, NJ: Center for Policy Research in Education, Rutgers University, 1987).

[9] National Day Care Study figures come from Craig Coelen et al., *Day Care Centers in the U.S.: A National Profile 1976-77*, Abt Associates, Volume 3: *Final Report of the National Day Care Study* (December 1978); the figures are based on a national probability sample of day care centers. The survey reports responses to a questionnaire and is probably severely biased; it is surprising that the averages are close to the NDCS averages. Current Population Survey figures, as yet unpublished by the Bureau of Labor Statistics, are reported in the NAEYC's *In Whose Hands? A Demographic Fact Sheet on Child Care Providers* (Washington, DC, 1987). Census figures come from the U.S. Census, *Earning by Occupation and Industry*; these are figures for child care workers, excepting private household workers. The Title XX salaries were reported in *Day Care and Child Development Reports* (February 1982). The salaries for the Perry Preschool are taken from W. Steven Barnett, *The Perry Preschool and Its Long-Term Effects: A Benefit-Cost Analysis*. Figures for California's publicly subsidized child care come from *The Cost of State Subsidized Child Care in California* (Berkeley, CA: MPR Associates, 1986). The various salaries from California were taken from leaflets available from the Child Care Employment Project, Oakland. All use methods intended to survey a random sample of child care workers. Public school teacher salaries come from the National Center for Education Statistics, *The Condition of Education*, 1985 edition.

[10] Lyda Beardsley, *Child Care Quality from the Children's Perspective: A Hypothetical Account and Research Review*, (Berkeley, CA: Policy Analysis for California Education, 1989).

[11] The Gallup Organization.

[12] Sandra Scarr, *Mother Care/Other Care* (New York: Basic Books, 1984); Alison Clarke-Stewart, *Daycare* (Cambridge, MA: Harvard University Press, 1982).

[13] Child Development Division, California State Department of Education, *Program Facts for 1986-87*.

[14] Horror stories have been a frequent and damaging part of the debate over child care. In 1968, Mary Dubling Keyserling published *Windows on Child Care*, a thoroughly nonrandom survey of child care by the National Council of Jewish Women. She reported one program that had more than forty children cooped up in barrels, cubbyholes, and other horrible spaces, and this report is still cited as evidence of how bad child care can be. In California, Patricia Bourne and her colleagues published *Day Care Nightmare* in 1971; the report's rhyming title suggested much about the state of child care.

[15] Dan Bellm, "The McChild Care," *Mother Jones*, April 1987.

[16] There is currently no significant difference in the costs of public and private facilities that are publicly subsidized, though there are differences in the composition of costs: public agencies tend to pay teachers more but pay less for space (which is often donated), while community-based agencies pay teachers less but are forced to pay more for space. See Susan Choy and others, *The Cost of State-Subsidized Child Care in California*, (Berkeley, CA: MPR Associates, 1986). In instituting the latchkey program for after-school care, the legislature was especially concerned that the cost of publicly funded care not exceed the cost in the private sector; but a recent investigation found average costs per hour in publicly funded programs to average $1.75 while private providers were charging more, between $1.94 and $2.22 per hour. Susan Choy and others, *School-Age Community Child Care Program Study: Summary of Major Findings* (Berkeley, CA: MPR Associates, 1987).

[17] Lawrence Schweinhart and Jeffrey Koshel, *Policy Options for Preschool Programs*, High/Scope Early Childhood Policy Paper No. 5 (Ypsilanti, MI: The High/Scope Press, 1986).

[18] In figures reported by the state Department of Education, the average daily rate for AP programs in 1986-87 was $15.60, compared to $19.60 for school-based programs, $17.56 for private general child care, and $16.06 for Title 22 programs. In unpublished figures calculated by MPR Associates, the cost per hour of AP programs in 1986 was $2.07, compared to $2.41 for public programs, $2.72 for publicly subsidized private programs, $2.32 for campus child care, and $3.55 for Title 22 programs.

However, the differences among the first five types of programs were not statistically significant because of large variations within program types. The lower cost for AP programs may be due to their greater use of family day care and location in lower-cost rural areas, rather than to intrinsically lower costs. For after-school programs, direct costs are 13 percent lower in AP programs than others, but administrative costs make total costs 27 percent higher; see Susan Choy and others, *School-Age Community Child Care Program Study.*

[19] *Evaluation of the JTPA Child Care Program created by the Child Care and Employment Act: Progress Report* (Berkeley, CA: MPR Associates, 1987).

[20] *Who is Watching Our Children? The Latchkey Child Phenomenon,* California Senate Office of Research (1983).

[21] Nanci Anderson, *Making Child Care Affordable: California Tax Policy Alternatives* (Berkeley, CA: Graduate School of Public Policy, University of California, 1987). This estimate is based on a careful methodology using CPS figures on families with different characteristics. The Swoap task force named a value, without citation, of $3 million in 1984, which seems much too low. See Swoap Committee: *A Report to the Governor from the Child Care Task Force,* 1985.

[22] The state's child care credit is between 5 percent and 10 percent of the federal credit, but closer to 5 percent because of nonrefundability. If we assume that the state credit is on the average 6 percent of the federal credit, and the state credit amounts to $20.1 million, then the federal credit was about $335 million to $350 million given in the report of the Swoap committee.

[23] Helen Bank and Amy Wilkins, *State Child Care Fact Book 1986* (Washington, DC: Children's Defense Fund, 1986).

[24] These estimates, like legislation and sausages, are best not scrutinized too closely. Estimates of the numbers of children served by age in 1986–87 came from the triennial report, "Program Facts for 1986–87," Child Development Division, California State Department of Education, Sacramento, 1987. Estimates of the proportions of children in different age groups with working parents *and* with incomes below 84 percent of the state median are available only from the 1980 Census. These proportions, calculated by the California State Census Data Center, are then applied to the PACE estimates of the numbers of children by age for 1985–86 to obtain estimates of the numbers of children by age in 1986 who were both in need of child care and below 84 percent of median income. The participation rates we calculate are, if anything, overestimates because poverty rates have increased between 1980 and 1986, and female labor-force participation rates have continued to increase; therefore the 1980 Census proportions for children in need of child care and eligible for public subsidy are certainly too low.

[25] A recent survey revealed that, of those in programs serving teenage mothers, 71 percent reported that child care was available to all enrolled, and another 13 percent reported child care for some children. However, in 1985 only 18,500 teenage mothers received services out of about 157,000 pregnant and parenting teens, so again it is clear that there is substantial unmet need. Increased amounts of child care headed the list of recommendations for expanded resources in Helen Cagampang, William Gerritz, and Gerald Hayward, *Pregnant and Parenting Minors and California Schools,* (Berkeley, CA: Policy Analysis for California Education, 1987).

[26] For example, when Title XX provided substantial federal funding for child care, DSS initially had administrative responsibility for child care programs; but the irrationality of DSS supporting child care programs while SDE administered a parallel set of programs (the Children's Centers) led to a decision to make SDE the administrator of Title XX programs. However, the interagency agreements between the two agencies were always difficult to negotiate and a source of constant friction. Other battles have arisen over whether DSS has the right to license SDE programs.

[27] Lyunn DeLapp, *Caring for Tomorrow: A Local Government Guide to Children,* California Assembly Office of Research, Sacramento, December 1985.

[28] Merle Lawrence, *California Child Care Initiative Year-End Report, October 1985–September 30, 1986* (San Francisco, CA: California Child Care Resource and Referral Network, 1987).

[29] Sandra Burud, Pamela Aschbacher, and Jacquelyn McCroskey, *Employer-Supported Child Care: Investing in Human Resources* (Dover, MA: Auburn House, 1984).

[30] Alfred Kahn and Sheila Kamerman, *Child Care: Facing the Hard Choices* (Dover, MA: Auburn House, 1987).

[31] California Department of Finance, *Populations Projections for California Counties 1980–2020 with Age/Sex Detail to 2020,* Report 86 P-3, 1986.

[32] The model of child care policy directed locally by R&R agencies has been promoted by Kahn and Kamerman based on the California experience; they imagine the R&R agencies in California to be much more powerful than they currently are. See especially Chapter 2 in Kahn and Kamerman.

Chapter 6

[1] Unless otherwise specified, the statistics appearing in this chapter are taken from and fully explained in the PACE publication, *Conditions of Education in California 1988*. Also, portions of the texts regarding teacher characteristics, student achievement, and school finance were adapted from the same publication.

[2] While schooling is statutorily compelled, attendance at a public school is not mandatory. Under a 1925 U.S. Supreme Court decision, state requirements for schooling may be fulfilled by a child's attendance at private school (*Pierce v. Society of Sisters*, 268 U.S. 510).

[3] This is an increase of 5 days over the 175-day average that prevailed in 1983.

[4] In 1988, this translated to approximately 529,000 students in private schools, a number that has remained remarkably stable over the past two decades.

[5] Between one-third and one-fourth of all new immigrants to the United States settled initially either in the Los Angeles or San Francisco areas.

[6] Data for the nation derived from *1988 Education Indicators* (U.S. Department of Education, National Center of Educational Statistics, 1988).

[7] This assumes that "school" in these instances refers to a single site, not multiple sites listed under a single school name.

[8] *Fact Sheet: Back-to-School Information 1988*, (Public Relations Office, California State Department of Education, August 1988), p. 8.

[9] C. Quinlan, C. George, and T. Emmett, *Year-round Educaton: Year-round Opportunities. A Study of Year-round Education in* California (California State Department of Education, Sacramento, 1988).

[10] J.W. Guthrie, Michael W. Kirst, et al., *Conditions of Education in California 1988*, Berkeley, CA: Policy Analysis for California Education (PACE), 1988.

[11] Ibid.

[12] Ibid.

[13] *Serrano v. Priest*, Civil No. 938, 254 (California Superior Court, April 10, 1974).

[14] This omits technical complexities such as "Union" and "Joint Union" school districts.

Chapter 7

[1] Jerald Bachman, Lloyd D. Johnston, and Patrick M. O'Malley, *Monitoring the Future: Questionnaire Responses from the Nation's High School Seniors*. Ann Arbor, MI: Survey Research Center, Institute for Social Research, 1975.

[2] Elliott A. Medrich, Judith Roizen, Victor Rubin, and Stuart Buckley, *The Serious Business of Growing Up: A Study of Children's Lives Outside School* (Berkeley: University of California Press, 1982).

[3] Susan Goff Timmer, Jacquelynne Eccles, and Keith O'Brien, "How Children Use Time," in F. Thomas Juster and Frank P. Stafford (eds.), *Time, Goods, and Well-Being* (Ann Arbor, MI: University of Michigan, Survey Research Center, Institute for Social Research, 1985).

[4] Judith Erickson, *A Profile of Community-Youth Organization Members*, 1980, The Boys Town Center for the Study of Youth Development. Erickson draws on the *High School and Beyond* study by the National Center for Education Statistics.

[5] "Where Children Play–A Report on After-School Recreational Resources in San Francisco." Coleman Advocates for Children and Youth, San Francisco, California, 1986.

[6] Immediately after World War II, inflation and economic expansion brought large numbers of teenagers into the labor force, particularly into the retail and service sectors, which historically have depended on minimum-wage and part-time employees. This trend was supported by a succession of national education task forces that argued that youth employment was needed in order to assist young people cross bridges into the world of adulthood. Indeed, during the 1970s, large numbers of high schools began to grant academic credit for time spent in employment, and they began to develop flexible schedules for students who combined employment with high school study. Even today, dropout prevention and recovery programs characteristically attempt to encourage students who need or want jobs to develop "contracts" that allow them to combine study and employment.

[7] Debra Viadero, "More and More Students are Juggling Conflicting Demands," *Ed Week* 6, 34:17, May 20, 1987.

[8] *Monitoring the Future: Questionnaire Responses from the Nation's High School Seniors*, 1986.

[9] Ivan Charner and Bryna Shore Fraser, *Youth and Work: What We Know, What We Don't Know, What We Need to Know* (Washington, DC: The William T. Grant Foundation on Work, Family, and Citizenship, 1987).

Chapter 8

[1] Health status data of the sort collected by national health surveys are not collected systematically at the state level. The National Center for Health Statistics publishes only national or regional data. However, the Center generously made available to this study its California survey data for 1984 and 1985. Two statistical caveats: the survey was not designed to produce state-level estimates and thus the California sample may not be properly representative of the California population; secondly, the sample size—5,850 children under the age of 18—is insufficient for making confident analyses of subpopulations, such as poor children, on particular measures. Such limitations suggest it would be more appropriate to consider patterns of results rather than any single finding for a subpopulation.

[2] The infant mortality rate is determined by dividing the number of deaths of California-born children less than by the number of live births in California.

[3] United States Statistical Abstracts, 1987.

[4] Children's Defense Fund, 1988.

[5] Babies born prior to thirty-seven weeks of gestation are considered premature.

[6] Institute of Medicine, Committee to Study the Prevention of Low Birthweight, *Preventing Low* Birthweight (Washington, DC: National Academy Press, 1985).

[7] R. L. Williams and P. M. Chen, "Identifying the Sources of the Recent Decline in Perinatal Mortality Rates in California," *New England Journal of Medicine* 306:207–14 (1982).

[8] Perinatal Regionalization, California Children's Services, High Risk Infant Follow-up by the Maternal and Child Health Branch of the Department of Health Services, the Department of Developmental Disabilities, and the Special Education Branch of the Department of Special Education.

[9] Institute of Medicine, 1985.

[10] Shah and Abbey, 1971; Gortmaker, 1979; Lee et al., 1980; McCormick, "The Contribution of Low Birthweight to Infant Mortality and Childhood Morbidity," *New England Journal of Medicine* 312:82–89 (1985); Behrman, 1986; Hogue et al., 1987.

[11] McCormick, 1985.

[12] G. Avery, "Effects of Social, Cultural and Economic Factors on Brain Development," in J. M. Freeman (ed.), *Prenatal and Perinatal Factors Associated with Brain Disorders*, NIH Publication No. 85-1149 (1985) pp. 163–76.

[13] McCormick et al., 1984.

[14] D. B. Binsacca, J. Ellis, D. B. Martin, and D. B. Petitti, "Factors Associated with Low Birthweight in an Inner-City Population: The Role of Financial Problems," *American Journal of Public Health* 1987, 77:505-6.

[15] Southern California Child Health Network, *Back to Basics: Improving the Health of California's Next Generation*, report of the Southern California Child Health Network and the Children's Research Insititute of California, (Santa Monica, CA: Southern California Child Health Network 1987).

[16] H. C. Miller, K. Hasanein, and P. A. Hensleigh, "Maternal Factors in the Incidence of Low Birthweight Infants Among Black and White Mothers," *Pediatric Research* , 12:1016–9 (1978).

[17] Gortmaker, 1979.

[18] Children's Defense Fund, 1988.

[19] Lennie et al., 1987.

[20] J. R. Bragonier, I. M. Cushner, and C. J. Hobel, "Social and Personal Factors in the Etiology of Preterm Birth," in F. Fuchs and P. G. Stubblefield (eds.), *Preterm Birth* (New York: MacMillan, 1984).

[21] C. C. Korenbrot, "Risk Reduction in Pregnancies of Low-Income Women: Comprehensive Prenatal Care Through the OB Access Project," *Mobius* 4:34-43 (1984).

[22] Cooney, 1985, Ingram et al., 1986.

[23] R. B. Gold and A. M. Kenney, "Paying for Maternity Care," *Family Planning Perspectives* 17:103-111 (1985).

[24] F. A. Sloan, J. Valvona, and R. Mullner, "Identifying the Issues: A Statistical Profile in Uncompensated Hospital Care, Rights and Responsibilities," in F. A. Sloan, J. F. Blumstein, and M. Perrin (eds), (Baltimore, MD: Johns Hopkins University Press, 1986).

[25] U. S. General Accounting Office, Comptroller General of the United States, *Report to the Congress of the United States: Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care*, HRD-87-137 (Washington DC: U.S. General Accounting Office, 1987).

[26] Jones and Hamburger, 1976; Mitchell and Schurman, 1984.

[27] Korenbrot, 1988.

[28] American Academy of Pediatrics, District 9, Committee on Health Planning. *California Health Plan for Children, 1979* (American Academy of Pediatrics: 1979).

[29] Chinh T. Le, letter in "Pediatric Forum," *American Journal of Diseases of Children* 140:615–617 (July 1986).

[30] Saul Krugman, "Rubella Immunization: Progress, Problems and Potential Solutions," Editorial, *American Journal of Public Health* 69, no.

3:217-219 (March 1979).

[31] White, et al., "Benefits, Risks and Costs of Immunization for Measles, Mumps and Rubella," *American Journal of Public Health*, 739-744 (July 1985).

[32] P. F. Agran, D. E. Dunkle, and D. G. Winn, "Motor Vehicle Accident Trauma and Restraint Usage Patterns in Children Less than Four Years of Age," *Pediatrics*, 76:382 (1985); P. F. Agran, D. E. Dunkle, and D. G. Winn, "Noncreash Motor Vehicle Accidents: Injuries to Children in the Vehicle Interior," *American Journal for Diseases of Children* 139:304 (1985); P. F. Agran, D. E. Dunkle, and D. G. Winn, "Injuries to a Sample of Seatbelted Children Evaluated and Treated in a Hospital Emergency Room," *The Journal of Trauma*, 27:58 (1987).

[33] Life Sciences Research Office, 1984.

[34] Legislative Analysts Office, *Public Assistance in California: Facts and Figures*. (Sacramento: Legislative Analysts Office, 1984).

[35] Food Research and Action Center, *Food Prices–Fact and Fiction: Assessing the Adequacy of USDA's Thrifty Food Plan* (Washington DC: Food Research and Action Center, 1985).

[36] Larry Brown, "Hunger in the United States," *Scientific American*, 256:2 (February 1987).

[37] U. S. Department of Agriculture, *Media Fact Sheet: Food Stamps* (Washington, DC: USDA Food and Nutrition Service, 1987); U. S. Deparment of Agriculture, *Food Stamp Program* (Washington DC: USDA Food and Nutrition Service, 1987).

[38] Maurice MacDonald, "Food Stamps and Food Need," *Focus* 10:1 (Spring 1987).

[39] U. S. Department of Agriculture, *Media Fact Sheet: Food Stamps* (Washington, DC: USDA Food and Nutrition Service, 1987); U. S. Deparment of Agriculture, *Food Stamp Program* (Washington, DC: USDA Food and Nutrition Service,.1987).

[40] California Department of Social Services, 1984, 1986.

[41] Bread for the World Educational Fund, *America '85: A Report of "Hunger Watch U.S.A."* (Washington, DC: Bread for the World Educational Fund, 1985.

[42] Food Research Action Center, 1985.

[43] United States Senate, *Evaluation and Reauthorization of the Special Supplemental Food Program for Women, Infants, and Children*, hearings before the subcommittee on Nutrition (Washington, DC: U.S. Senate, 1984).

[44] E. T. Kennedy, S. Gershoff, R. B. Reed, and J. E. Austin, "Evaluation of the Effect of WIC Supplemental Feeding on Birthweight," *Journal of the American Dietetic Association* 80:220-7 (1982).

[45] California State Department of Health Services, *State Participation and Costs, FY 1980-1985* (Sacramento: CSDHS, Maternal and Child Health Branch, WIC Supplemental Food Section, 1986); California State Department of Health Services, *WIC State Plan., FY 1987* (Sacramento: CSDHS, Maternal and Child Health Branch, WIC Supplemental Food Section, 1986).

[46] Ibid.

[47] Bread for the World Educational Fund, 1985.

[48] U. S. Department of Agriculture, *Food Stamp Certified Eligibility Household Characteristics Survey, March, 1985* (Washington, DC: USDA Food and Nutrition Service, 1985).

[49] U. S. Department of Agriculture, *NEWS* (San Francisco: USDA Food and Nutrition Service, Western Region, 1987).

[50] U. S. Department of Agriculture, *The National Evaluation of School Nutrition Programs, 1983* (Washington, DC: USDA Food and Nutrition Service, 1983).

[51] Bread for the World Educational Fund, 1985.

[52] Ibid.

[53] *Sacramento Bee*, Sacramento, CA, 1987.

[54] San Francisco Task Force on Food and Hunger, 1986.

[55] *Sacramento Bee*. Hunger Survey. Special reprint of a series, "Need in the Midst of Plenty," Sacramento, CA, February 22, March 29, 1987.

[56] San Francisco Task Force on Food and Hunger. *Feeding the Hungry in the City of St. Francis* (San Francisco: Task Force on Food and Hunger, 1986.

[57] Bread for the World Educational Fund, 1985.

[58] *Sacramento Bee*, 1987.

[59] Ibid.

[60] Fuchs, 1983.

[61] Ibid.

[62] C. Brindis, C. Korenbrot, and L.Seltzer, "California School-Based Clinic Evaluation–One-Year Progress Report" (San Francisco: Center for Population and Reproductive Health Policy, Institute for Health Policy Studies, University of California at San Francisco, August 1987).

[63] Skager, Frith and Maddahian, *Second Statewide Survey of Drug and Alcohol Use Among California Students in Grades 7, 9, 11.* Prepared for Attorney General John K. Van de Kamp, 1988.

[64] Ibid.

[65] *Illicit Drug Use by American High School Seniors.*(Ann Arbor: University of Michigan, 1988).

[66] Skager, Frith and Maddahian, 1988.

[67] Hofferth and Hayes, 1987.

[68] California Department of Finance, 1986

[69] C. Brindis and R. Jeremy, "Adolescent Pregnancy and Parenting in California: Building a Strategic Plan for Action," unpublished paper, Institute for Health Policy Studies, University of California, San Francisco, 1988.

[70] A. Loomis, C. Brindis, and C. Korenbrot, "Teenage Pregnancy and Parenting Program: A Formula for School Dropout Prevention," handbook prepared for the California State Department of Education, High-Risk Youth Dropout Prevention Program, Sacramento, California, June, 1987.

[71] J. Cramer, "The Risks of Children Bearing Children: Maternal Age, Marital Status, and Infant Health," unpublished paper presented at the Pacific Sociological Association, Eugene, Oregon, April 1987.

[72] P. Rothenberg and P. E. Varga, "The Relationship Between Ages of Mother and Child Health and Health Development," *American Journal of Public Health* 71:810–817 (1981).

[73] J. Marecek, *Economic, Social and Psychological Consequences of Adolescent Childbearing: An Analysis of Data from the Philadelphia Perinatal Project*, final report to the National Institute for Child and Human Development (Swarthmore, PA: Swarthmore University, 1979).

[74] K. A. Moore and M. R. Burt, *Private Crisis, Public Cost: Policy Perspectives on Teenage Childbearing* (Washington, DC, Urban Institute, 1982).

[75] Alan Guttmacher Institute, "Teenage Pregnancy: The Problem that Hasn't Gone Away" (New York: Alan Guttmacher Institute, 1981).

[76] M. Burt, "Estimates of Public Costs for Teenage Childbearing," unpublished paper prepared for the Center for Population Options, Washington, DC, 1986.

[77] Brindis and Jeremy, 1988

[78] J. Dryfoos, "Inter-Relationships of Risk-Taking Behavior Among Youth," unpublished paper prepared for the Carnegie Foundation, New York, 1987.

[79] CDF, 1986

[80] H. Cagampang, W. Gerritz, and G. Hayward, *Pregnant and Parenting Minors in California Schools* (Berkeley: Policy Analysis for California Education [PACE], University of California, 1987).

[81] R. Simpson, *Services for Pregnant and Parenting Minors and California Schools*, unpublished report to the California State Department of Education, November 1987.

[82] V. Warner and R. Simpson, *A Declaration for Change in the 90s: Policies and Issues for Teenage Pregnancy and Poverty* (Sacramento, CA: Enterprises Management and Development Corporation, 1986.

[83] Simpson 1987

[84] C. Hayes, *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing*, Vol. I (Washington, DC: National Academy Press, 1987).

[85] H. F. Pollick, A. J. Rice, and D. Echenberg, "Dental Health of Recent Immigrant Children in San Francisco Elementary Newcomer Schools," *American Journal of Public Health*, 1987.

[86] California Department of Developmental Services, *Long-Range Plan, 1986-91* (Sacramento: Department of Developmental Services, December 1986).

[87] Forrest C. Bernet, "Neurodevelopmental Outcome of Low Birth Weight Infants: Historical and Current Perspectives," High Risk Infants: 1986, Advances in Follow-up and Intervention Conference, September 1985.

[88] Developmental Disabilities Area Board III, *1985 Needs Assessment Data* (Sacramento, CA: Developmental Disabilities Area Board III, December 1985); Developmental Disabilities Area Board I, *1987 Needs Assessment* (Sacramento, CA: Developmental Disabilities Area Board I, May 1987); Developmental Disabilities Area Board X, *Cycle X Program Development Fund Priorities*, (Los Angeles, CA: Developmental Disabilities Area Board 10, May 1986).

[89] Ibid.

[90] Linda Toms and Deborah Kogan, *Study of the Federal Definition of Developmental Disabilities* (Sacramento, CA: Berkeley Planning Associates, 1983).

[91] R. Jeremy and C.Korenbrot, *Coordination Among Agencies Serving High-Risk Infants* (San Francisco: Center for Population and Reproductive Health Policy Studies, Institute for Health Policy Studies, School of Medicine, University of California at San Francisco, 1987).

[92] P. Newacheck, P. Budetti, and N. Halfon, "Trends in Activity-Limiting Chronic Conditions Among Children," *American Journal of Public Health* 76:178 (1986).

[93] U.S. Census, CPS

[94] E. R. Brown et al., "Californians Without Health Insurance," California Policy Seminar, Technical Assistance Report, February 1, 1987.

[95] P. Newacheck and N. Halfon, "The Financial Burden of Medical Care Expenses for Children," *Medical Care*, 24:1110 (1986).

[96] Perloff 1985.

[97] N. Halfon and P. Newacheck, "Capitation in California: An Analysis of At-risk Financing of Medicaid Services," *Western Journal of Medicine* 145:258 (1986)..

Chapter 9

[1] D. P. Cantwell, DSM-III Studies, *Assessment and Diagnosis in Child Psychopathology*, 1:3-34, M. Rutter, A.H. Tuma, and I.S. Lann, eds. (New York and London: The Guilford Press, 1988).

[2] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition, revised (Washington, DC: American Psychiatric Association, 1987).

[3] Ibid.

[4] U.S. Congress, Office of Technology Assessment, *Children's Mental Health: Problems and Services - A Background Paper*, OTA-BP-H-33 (Washington, DC: U.S. Government Printing Office, 1986.

[5] California Assembly Bills 3632 (Chapter 1747/1984) and 882 (Chapter 1274/1985) mandate the Department of Mental Health to assume responsibility for providing all related services, including assessment and mental health services, for children in special education who are identified in an Individual Education Plan (PL 94-142) as requiring such services in order to benefit from their education.

[6] M. Gould, R. Wunsch-Hitzig, and B. Dohrenwend, "Estimating the Prevalence of Childhood Psychopathology," *Journal of the American Academy of Child Psychiatry* 20:462-476(1981); L. Klee, C. Schmidt, and C. Johnson, "Children's Definitions of Family Following Divorce of Their Parents," *The Journal of Divorce* 12(2) (1988).

[7] I. Lourie and J. Katz-Leavy, "Severely Emotionally Disturbed Children and Adolescents" (Washington, DC: Underserved Populations Branch, Office of State and Community Liaison, NIMH).

[8] U.S. Congress, Office of Technology Assessment, 1986.

[9] Rutter, 1988.

[10] S. Parker, S. Greer, and B. Zuckerman, "Double Jeopardy: The Impact of Poverty on Early Child Development" *The Pediatric Clinics of North America* 35(6):1227-1240 (1988).

[11] L. Olsen, *Crossing the Schoolhouse Border: Immigrant Students and the California Public Schools* (San Francisco: California Tomorrow, 1988).

[12] L. Klee and N. Halfon, "Mental Health Care for Foster Children in California" *Child Abuse and Neglect* 11:63-74 (1987).

[13] U.S. House of Representatives, Select Committee on Children, Youth, and Families. *Abused Children in America: Victims of Official Neglect* (Washington, DC: U.S. House of Representatives, March 1987.

[14] L. Murphy, L, "Long-term Foster Care and Its Influence on Adjustment to Adult Life," in E.J. Anthony and C. Koupernic (eds.), *The Child in His Family: Children at Psychiatric Risk.* (New York: Wiley, 1974).

[15] A Brenner, *Helping Children Cope with Stress* (Lexington, MA: Lexington, D. C. Heath, 1985).

[16] B. Egeland and L. A. Sroufe, "Developmental Sequelae of Maltreatment in Infancy," in R. Rizley and D. Cicchetti (eds.), *Developmental Perspectives on Child Maltreatment* (San Francisco: Jossey-Bass, 1981).

[17] Lourie and Katz-Leavy.

[18] California Alcohol Program State Plan, Fiscal Year 1986-1987 (Sacramento: California Department of Alcohol and Drug Programs, May 1987).

[19] G. Lawson, J. S. Peterson, and A. Lawson, *Alcoholism and the Family* (Rockville, MD: Aspen, 1983).

[20] Parker, Greer, and Zuckerman, 1988.

[21] U.S. Congress, Office of Technology Assessment, 1986.

[22] D. A. Wolfe, *Child Abuse: Implications for Child Development and Psychopathology* (Beverly Hills, CA: Sage, 1987).

[23] National Institute for Alcohol Abuse and Alcoholism, *Sixth Annual Report to U.S. Congress* (Washington, DC: National Institute for Alcohol Abuse and Alcoholism, 1987)..

[24] Wolfe, 1987.

[25] Ibid.

[26] Ibid, 1987.

[27] P. W. Newacheck, P. Budetti, and N. Halfon, "Trends in Childhood Chronic Illness," *American Journal of Public Health* 76:178-184 (1986).

[28] Wolfe, 1987.

[29] U.S. Congress, Office of Technology Assessment, 1986.

[30] Unpublished tabulation of the National Health Interview Survey (NHIS).

[31] R. A. Schurman, P. D. Kramer, and J. B. Mitchell, "The Hidden Mental Health Network: Treatment of Mental Illness by Non-psychiatrist Physicians," *Archives of General Psychiatry* 42(1):89-94 (1985).

[32] V. Seitz, L. K. Rosenbaum, and N. H. Appel, "Effects of Family Support Intervention: A Ten-Year Follow Up," *Child Development* 56:376 (1985).

[33] E. L. Cowen, E. L. Gesten, and R. P. Weisberg, "An Integrated Network of Preventively Oriented School-Based Mental Health Approaches," in R. H. Price and P. Politzar (eds.), *Evaluation and Action in the Community Context.* (New York: Academic Press, 1980).

[34] R. W. Chamberlain, "Developmental Assessment and Early Intervention Programs for Young Children: Lessons Learned from Longitudinal Research," *Pediatrics* 8, no. 8: 237-247 (1987); and C. M. Heinicke, L. Beckwith, and A. Thompson, "Early Intervention in the Family System: A Framework and Review," *Infant Mental Health Journal*. 9, no. 2 (1988).

[35] E. F. Zigler, "Assessing Head-Start at 20: An Invited Commentary," *American Journal of Orthopsychiatry* 55(4):603609 (1985).

[36] E. F. Zigler and W. Berman, "Discovering the Future of Early Childhood Intervention," *American Psychologist* 38:894 (1983).

[37] S. Provence and A. Naylor, *Working with Disadvantaged Parents and Their Children, Scientific and Practice Issues*. (New Haven and London: Yale University Press, 1983).

[38] Seitz, Rosenbaum, and Appel, 1985.

[39] J. Burrueta-Clement, W. Schweinhart, S. Burnett, et al., *Changed Lives: The Effects of the Perry Preschool Program on Youth Through Age 19* (Ypsilanti, MI: The XXXXX Scope Press, 1984).

[40] S. Fraiberg, *Clinical Studies in Infant Mental Health: The First year of Life* (New York: Basic Books, 1980).

[41] A. F. Lieberman, "Infant Mental Health: A Model for Service Delivery," *Journal of Clinical Child Psychology* 14:196-201 (1985).

[42] E. J. Costello, "Primary Care Pediatrics and Child Psychopathology: A Review of Diagnostic, Treatment, and Referral Practices," *Pediatrics* 78:1044-1051 (1986).

[43] Klee and Halfon, 1987.

[44] Ibid.

[45] U.S. Congress, Office of Technology Assessment, 1986.

[46] Ibid.

[47] M. E. Glasser, "Mental Health Consultation and Long-Term Planning for Foster Children," in M. Hardin (ed.), *Foster Children in the Courts* (Boston: Butterworth, 1983).

[48] Klee and Halfon, 1987.

[49] U.S. Congress, Office of Technology Assessment, 1986.

[50] California State Department of Mental Health, Division of Community Programs, Special Populations Branch. California Child and Adolescent Service System Program Grant Application: A State Level Project Serving Seriously Emotionally Disturbed Children and Adolescents. January, 1988.

Chapter 10

[1] N. Halfon and L. Klee, "Health Care for Foster Children in California," unpublished monograph available from the Institute for Health Policy Studies, University of California, San Francisco, California, 1986; L. Klee and N. Halfon, "Mental Health Care for Foster Children in California," *Child Abuse and Neglect* 11:63-74 (1987).

[2] H. P. Martin, "Abused Children—What Happens Eventually," in K. Oates (ed.), *Child Abuse: A Community Concern* (New York: Brunner/Mazel, n.d.).

[3] P. Mintzies and I. Hare, *The Human Factor: A Key to Excellence in Education* (Silver Spring, MD: National Association of Social Workers, 1985).

[4] R. P. Barth and D. Schleske, "Comprehensive Sexual Abuse Treatment Programs and Reports of Sexual Abuse," *Children and Youth Services Review* 7:285-298 (1985).

[5] Report by Los Angeles County for Legislative Roundtable Discussion on Child Welfare Services Funding, Sacramento, California, April 29, 1988.

[6] D. J. Besharov, "Doing Something About Child Abuse: The Need to Narrow the Grounds for State Intervention," *Harvard Journal of Law and Public Policy* 8, no. 3:539-589 (1985).

[7] R. P. Barth and M. Berry, "Outcomes of Child Welfare Services Since Permanency Planning," *Social Service Review* 61:71-90 (1987); D. Fanshel and E. B. Shinn, *Children in Foster Care: A Longitudinal Investigation* (New York: Columbia University Press, 1979).

[8] American Humane Association, *Highlights of Official Child Neglect and Abuse Reporting*, 1985 (Denver: American Humane Association, 1987).

[9] J. M. Giovannoni, *Final Report: Private Individuals' Reports of Child Abuse and Neglect* (Los Angeles: University of California, no date).

[10] American Humane Association.

[11] Giovannoni.

[12] National Committee for Prevention of Child Abuse, *Child Abuse Deaths* (Chicago: National Committee for Prevention of Child Abuse, 1987).

[13] K. K. Christoffel, K. Liu, and J. Stamler, "Epidemiology of Child Abuse: International Mortality Data," *Journal of Chronic Diseases* 34:57-64 (1981).

[14] "A Closer Look at Child Abuse Deaths," *San Francisco Examiner*, December 1, 1987.

[15] T. Armistead and S. LaPlante, *Deaths of Children in Foster Care and Emergency Shelter Care: A Preliminary Report* (San Francisco: Mayor's

Committee on Foster Care, 1986).

[16] Barth and Schleske, 1985.

[17] State of California Department of Social Services, *Preplacement Preventive Services, Emergency Response, and Family Maintenance Programs* (Sacramento: California State Department of Social Services, 1986).

[18] C. Sudia, "Preventing Out-of-Home Placement of Children: The First Step to Permanency Planning," *Children Today* 15:4-5 (1986).

[19] Children's Research Institute of California, "Preliminary Findings and Recommendations to the Bay Area Network Paper, 'Alternatives to Emergency Shelter Care,'" *Foster Care Network News* 4:1-4(1985).

[20] Ibid.

[21] Children's Research Institute of California, unpublished data, 1987.

[22] Children's Research Institute of California, "Preliminary Findings and Recommendations to the Bay Area Network Paper, 'Alternatives to Emergency Shelter Care,'" *Foster Care Network News* 5:1-4 (1987)

[23] M. Seashore, "The Effectiveness of Foster Youth Services in Four California School Districts," Report No. 1-86 (San Francisco: San Francisco State University, Public Research Institute).

[24] Children's Research Institute of California, unpublished data, 1987.

[25] R. P. Barth, "Emancipation Services for Adolescents in Foster Care," *Social Work* 31:165-171 (1986).

[26] T. Demchak, "Out of Foster Care, Into the Streets: Services Ordered for Homeless Youth," *Youth Law News* 6, no. 5:12-15 (1985); Senate Select Committee on Children, Youth and Families, *Update on Homeless Children and Families*, December 1987.

[27] E. L. Bassuk, L. Rubin, and A. S. Lauriat, "Characteristics of Sheltered Homeless Families," *American Journal of Public Health* 9:1097-1101 (1986).

[28] 238 *California Reporter* 232 (Cal. App. 2 Dist. 1987); *Clearinghouse Review* 40:807 (1987).

[29] Reported in "Homeless Children Face Increased Risk of Disease," *Youth Law News* 9, no. 2:22 (1988).

[30] Barth and Berry, 1987.

[31] R. C. Herrenkohl, E. C. Herrenkohl, B. Egolf, and M. Seech, "The Repetition of Child Abuse: How Frequently Does It Occur?" *Child Abuse and Neglect* Spring:67-72 (1979); W. E. Claburn, S. Magura, and S. P. Chizeck, "Case Reopening: An Emerging Issue in Child Welfare Services," *Child Welfare* 56:655-664 (1977); A. M. Butterfill, A. D. M. Jackson, and D. Nangle, "Child Abuse—A Two-Year Follow-Up," *Child Abuse and Neglect* 5:985-989 (1979).

[32] M. A. Jones, *A Second Chance for Families—Five Years Later: Follow-Up of a Program to Prevent Foster Care* (New York: Child Welfare League of America, 1983).

[33] M. S. Wald, J. M. Carlsmith, P. H. Leiderman, R. D. French, and C. Smith, *Protecting Abused/Neglected Children: A Comparison of Home and Foster Placement* (Stanford, CA: Stanford University, Stanford Center for the Study of Youth Development, 1985).

[34] Barth and Berry, 1987.

[35] Personal communication with Toshio Tatara, American Public Welfare Association, April 9, 1988.

[36] S. Smith and J. Lays (eds.), *Child Welfare in the States: Fifty State Survey Reports* (Denver: National Conference of State Legislatures, 1986).

[37] State of California Statistical Services Branch, unpublished data, 1987.

[38] Personal communication with Toshio Tatara (see note 35).

[39] Ibid.

[40] Report by Los Angeles County for Legislative Roundtable Discussion on Child Welfare Services Funding, Sacramento, California, April 29, 1988.

[41] State of California Foster Care Information System (FCIS), unpublished data, 1987.

[42] State of California, *County Fact Book* (Sacramento: State of California, 1987).

[43] State of California Legislative Analyst, *Child Welfare Services: A Review of the Effect of the 1982 Reforms on Abused and Neglected Children and Their Families* (Sacramento: State of California Legislative Analyst, 1985).

[44] M. S. Wald, J. M. Carlsmith, P. H. Leiderman, R. D French, and C. Smith, 1985; Fanshel and Shinn; J. Lahti, K. Green, A. Emlen, J. Zadny, Q. D. Clarkson, M. Kuehnel, and J. Casciato, *A Follow-Up Study of the Oregon Project* (Portland, OR: Portland State University, Regional Institute for Human Services, 1978); H. Leitenberg, J. D. Burchard, D. Healy, and E. J. Fuller, "Non-Delinquent Children in State Custody: Does Type of Placement Matter?" *American Journal of Community Psychology* 9:347-360 (1981).

[45] H. Maas and R. Engler, *Children in Need of Parents* (New York: Columbia University Press, 1959); A. Gruber, *Children in Foster Care: Destitute, Neglected, and Betrayed* (New York: Human Sciences Press, 1978).

[46] E. Fein, L. J. Davies, G. Knight, "Placement Stability in Foster Care," *Social Work* 24:56-157 (1979); N. M. Stone and S. F. Stone, "The Prediction of Successful Foster Placement," *Social Casework* 64:11-17 (1983).

[47] T. Festinger, *No One Even Asked Us* (New York: Columbia University Press, 1983).

[48] Demchak.

[49] State of California Legislative Analyst.

[50] Report by Los Angeles County for Legislative Roundtable Discussion on Child Welfare Services Funding.

[51] C. Campbell and S. W. Downs, "The Impact of Economic Incentives on Foster Parents," *Social Service Review* 12:599-609 (1987).

[52] K. Proch and M. A. Taber, "Alienated Adolescents in Foster Care," *Social Work Research and Abstracts* 23:9-13 (1987).

[53] Westat, Inc., Independent Living Services for Youth in Substitute Care (Washington, DC: U.S. Department of Health and Human Services, 1986).

[54] R. P. Barth, "Preparation of Adolescents in Foster Care for Independent Living," in T. Maluccio and J. Aldgate (eds.), *Adolescents in Foster Family Care* (London: Grower, in press).

[55] R. P. Barth and M. Berry, *Disruption: Rates, Risks and Responses* (New York: Aldine, 1988).

[56] Ibid.

[57] Ibid.

[58] J. Triseliotis and J. Russell, *Hard to Place: The Outcome of Adoption and Residential Care* (London: Heinemann, 1984); B. Tizard, *Adoption—A Second Chance* (New York: Free Press, 1977); R. G. McRoy, L. A. Zurcher, M. L. Lauderdale, and R. N. Anderson, "Self-Esteem and Racial Identity in Transracial and Inracial Adoptees," *Social Work* 37:522-526 (1982).

[59] Triseliotis and Russell.

[60] Westat, Inc.; R. J. Simon and H. Alstein, *Transracial Adoptees and Their Families* (New York: Praeger, 1987).

[61] R. P. Barth, M. Berry, R. Goodfield, and M. L. Carson, *Older Child Adoption and Disruption.* Prepared for the Administration on Children, Youth and Families, U.S. Department of Health and Human Services, Grant no. 90-PD100715.

[62] Urban Systems Research and Engineering, Inc., *Evaluation of State Activities with Regard to Adoption Disruption* (Washington, DC: Urban Systems Research and Engineering, Inc., 1985).

[63] Barth, Berry, Goodfield, and Carson.

[64] Barth and Berry (1988).

[65] W. H. Slingerland, *Child Welfare Work in California* (New York: Russell Sage Foundation, 1916).

[66] Lahti and others.

[67] M. Bush and A. C. Gordon, "The Case for Involving Children in Child Welfare Decisions," *Social Work* 27:309-314 (1982).

[68] Ibid.

[69] M. A. Jones and B. Moses, *West Virginia's Former Foster Children: Their Experience in Care and Their Lives as Young Adults* (New York: Child Welfare League of America, 1984).

[70] D. Fanshel, *On the Road to Permanency: An Expanded Data Base for Service to Children in Foster Care* (New York: Child Welfare League of America, 1982).

[71] M. Bush, "Institutions for Dependent and Neglected Children: Therapeutic Option or Last Resort?" *American Journal of Orthopsychiatry* 50:239-255 (1980).

[72] R. Barth, "On Their Own: The Experiences of Youth After Foster Care" (Berkeley: University of California, School of Social Welfare, 1988).

[73] State of California Legislative Analyst.

[74] R. B. Presley, "Hearing on Child Abuse Reporting Laws and Dependency Statutes," State of California Senate Select Committee on Children and Youth (Sacramento: Joint Publications, December 1986).

[75] Commission on California State Government Organization and Economy, *The Children's Services Delivery System in California.* Preliminary Report—Phase I. Contract no. G0E-600 (Sacramento: Commission on California State Government Organization and Economy, 1987).

Chapter 11

[1] This succinct phrase for the young people of concern in this chapter comes most recently from Barry Krisberg, "California's Juvenile Justice System in Turmoil," in John J. Kirlin and Donal R. Winkler (eds.), *California Policy Choices*, 1987. Krisberg gives a useful, if at times polemical, review of the issues facing the formal juvenile justice system in California—their sources, implications, and possible policy consequences.

[2] Throughout the chapter, we use the phrases *youth, young people, juveniles,* or *minors* interchangeably, as well as the more technical terms *juvenile* or *youthful offender.*

[3] Historians have begun to examine the linkages between compulsory school attendance, child labor laws, and the cycles of public concern with first "idle" and then "delinquent" youths. The fruits of this research are to stress how particular notions about delinquency emerge at specific moments in history and are expressed in public policies. The reforms, practices, and beliefs of one era often become the objects of reform at a later point.

[4] For a useful summary of the legal status of children and childhood in the U.S. legal culture, with reference to California where relevant, see Youth

Law Center, "Legal Rights of Children in the United States of America," *Columbia Human Rights Law Review* 13, no. 1 (1981).

[5] Legal definitions generally rely on either chronological age or civil status – some individuals under age 18, by virtue of marriage or other formal emancipation from the parental household, have adult legal status.

[6] Status offenses are covered under Section 601 of the Welfare and Institutions Code. These involve behaviors such as running away from (parental) home, truancy, curfew violations, "incorrigibility" – offenses particular to the status of being a minor; that is, behavior that would not be criminal if engaged in by an adult.

[7] Robert M. Carter, "The United States," in M.W. Klein (ed.), *Western Systems of Juvenile Justice* (Beverly Hills, CA: Sage, 1984).

[8] Edwards, 1988.

[9] Data on the characteristics of the system as a whole, as a process, and on the conditions of children and youths in it are, however, of variable quality if available at all. Moreover, thinking in "system" terms is a relatively new approach. Also, analysts are only beginning to recognize the complexities of various juvenile justice systems. See M.W. Klein (ed.), *Western Systems of Juvenile Justice* (Beverly Hills, CA: Sage, 1984).

[10] Ibid.

[11] C. P. Smith, T. E. Black, and F. R. Campbell, *A National Assessment of Case Dispositions and Classification in the Juvenile Justice System: Inconsistent Labeling*, Vol. 1 (Sacramento, CA: American Justice Institute, 1979).

[12] Ibid.; and K. T. Van Dusen and M. W. Klein, *Executive Summary: Assessment of the Impact of California's Juvenile Justice Reform Law* (Washington, DC: U. S. Department of Justice, NIJJDP, 1981).

[13] States such as Massachusetts, Pennsylvania, Oklahoma, Utah, and New Jersey have rates less than one-quarter that of California, achieved by taking advantage of alternative policies that deemphasize incarceration. No other major state currently has plans to expand its incarceral capacity. Indeed, a series of lawsuits over conditions in training schools and other correctional facilities brought against state youth authorities over the past twelve years has further dissuaded such expansion. See Ira Schwartz, "Emerging Trends and Promising Strategies in Juvenile Crime Control in the United States," *Youth Policy* 10, no. 1 (1988).

[14] This section draws on the discussion in Krisberg.

[15] Krisberg.

[16] Ibid.

[17] For a succinct overview of the federal role in juvenile justice policy, including a chronology of federal policy and a useful summary discussion of new issues and policy options at the intersection of juvenile justice with education, mental health, gender, and other policy areas, see June Bucy, "Juvenile Delinquency Efforts: The Search for Justice," *Youth Policy* (May 1987) and I. Schwartz (1988).

[18] I. Schwartz.

[19] National studies and presidential commissions concur that whether or not a juvenile becomes involved in the juvenile justice system usually depends on the outcome of an encounter with the police. In any given encounter, the range of alternatives available may vary considerably among departments and individual officers. Some encounters grow out of a criminal act of significant proportions, and contact is likely to lead to further processing by the justice system. Other encounters are based on relatively minor violations or not on a specific crime at all; on such occasions, a wider range of choices is available.

[20] In California, the Welfare and Institutions Code identifies those individuals who fall within the jurisdiction of the juvenile court. The delinquent child is:

> Any person who is under the age of 18 years when he violates any law of this state or the United States or any ordinance of any city or county of this state defining crime other than an ordinance establishing a curfew based solely on age, is within the jurisdiction of the juvenile court, which may adjudge such person to be a ward of the court. (Department of Youth Authority, 1981, Section 602)

The broad categorization of delinquent tendencies includes:

> Any person under the age of 18 years who persistently or habitually refuses to obey the reasonable and proper orders or directions of his parents, guardians, or custodian, or who is beyond the control of such person, or who is under the age of 18 years when he violates any ordinance of any city or county of this state establishing a curfew based solely on age is within the jurisdiction of the juvenile court. (Department of Youth Authority, 1981, Section 601).

The conditions under which a child may be categorized as a dependent child of the court are also specified in Section 300.

[21] Among other conventions occasioned by the prevailing philosophy of the juvenile justice system, a juvenile is technically not arrested but rather brought into custody by a police officer. Similarly, a young person is not charged with a crime but a delinquency petition may be filed in the court; a young person is not convicted, but rather his or her case is adjudicated, with the varied disposition options decribed later. Despite these formal conventions, official statistics on juvenile crime routinely report in the language of arrests.

[22] At the most obvious level, not all crimes are reported, nor are all perpetrators of crime identified, as we have noted. Arrest itself, of course, does not indicate guilt. So, arrest data provide a necessarily partial view of crimes committed. Several other problems may affect arrest data. Especially where juveniles are involved, law enforcement agencies have some formal and substantial informal discretion in what form this official contact may take. This point of first contact with the system is one of several crucial decision points where a variety of alternatives is available. Substantial research has raised the question about systematic variations in the decision to arrest or to deal informally with juveniles on the basis of sociodemographic characteristics of the youth, both at the level of agency as well as that of individual officers.

[23] Possession of a small amount of marijuana was reclassified as a misdemeanor in 1976, effectively lowering felony counts, although other felony arrests also declined during the period. Then, in 1977, prohibitions on the secure detention of juvenile status offenders had the immediate effect of reducing status offense arrests.

[24] Data are available for non-Hispanic whites, blacks, Hispanics, and "others." "Other" includes Native American and American Indians, Asian and Pacific Islander peoples, and all others.

[25] For a summary of this literature that discusses the strengths and weaknesses of these research efforts, see Barry Krisberg and James Austin, *The Children of Ishmael* (Mountain View, CA: Mayfield, 1978). They note especially the studies that have examined delinquency in middle- and upper-class communities and the interaction with police, probation officers, and court personnel. The common issue in much of this literature is the dynamics that inform and *define* the characteristics of the intervention chosen by police in the primary contact with potentially delinquent juveniles.

In sum, at each critical point in the process—police definition of the intervention at primary contact, decision among intake alternatives, and court dispositional alternatives—a variety of intervening factors from professional ideologies and available resources to the sociodemographic characteristics of the individual juveniles all confound the relation between objective severity or type of offense and consequences.

[26] *Crime and Delinquency in California*, 1986.

[27] Although probation offices are sometimes housed at a police or sheriff station, they are formally distinct and separate.

[28] *Crime and Delinquency in California*, 1986.

[29] This total includes those from law enforcement agencies, as well as an additional 12,000 from families, schools, and other sources.

[30] The term "new referral" means that the juvenile was not on probation or parole at the time of referral. This does not mean that the juvenile has not had previous contact with the juvenile justice system. Complete statewide statistics are only kept for new referrals.

In 1986, for an additional 26,871 youth already on probation or parole at the time of referral to a probation department (called "subsequent referral"), they were more likely to have a petition filed (76.5 percent), and once in the juvenile court, more likely to be placed on formal probation (79.7 percent), and substantially more likely to be committed to the Youth Authority (4.5 percent). Trends since the early 1980s show slight increases in petitions filed and formal probation, and very slight decreases in cases dismissed, transferred, or remanded, and in proportion committed to the Youth Authority.

For reasons of data reporting procedures, these figures do not include information from Alameda, Los Angeles, San Diego, and Santa Clara Counties.

[31] By the early 1970s, petitions filed had declined to about 30 percent of dispositions, and cases closed or transferred had risen to about 55 percent, so the 1985 figures suggest an increasing number of petitions filed over the period. Informal probation remained about the same over this time. See Unwin in Krisberg and Austin (eds.).

[32] Greenwood and Lipson, 1984.

[33] According to a recent CYA study, nearly two-thirds (72 percent) of juveniles in the camps have no contact with either the Youth Authority or the Department of Corrections within two years of their release. Rearrest rates run 67 percent within two years, but that figure includes any subsequent convictions or sustained petitions.

[34] The study, conducted by the Youth Authority at the request of the Chief Probation Officers Association of California and in cooperation with a CPOC-appointed Camps, Ranches, and School Research Advisory Committee, looked at the youth populations of all probation camps in the state.

See Ted B. Palmer and Robert F. Wedge, *California's Juvenile Probation Camps: General Features, Youths Served, and Program Overview* Part 1: *Statewide Findings* and Part 2: *Individual Camps Findings* (Sacramento: Department of Youth Authority, 1985); Evelyn Domingo-Llacuna, Doug Knight, and Ted B. Palmer, *California's Juvenile Probation Camps: Program Staff and Case Processing* (Sacramento: Department of Youth Authority, 1985); and, Robert F. Wedge and Ted Palmer , *California's Juvenile Probation Camps: Comparison of the Characteristics of Youths in Juvenile Justice Programs* (Sacramento: Department of Youth Authority, 1986).

[35] The data on the camp populations from this survey are useful. Particular analyses and findings of the study may deserve further critical scrutiny.

[36] Steve Lerner, *Bodily Harm: The Pattern of Fear and Violence at the California Youth Authority* (Bolinas, CA: Common Knowledge Press, 1986).

[37] *Justice Quarterly*.

[38] Legislative Analyst's Office, 1986.

[39] Rowland, 1986.

[40] Cramer, 1986.

[41] "Young Lawbreakers Jamming Country's Detention Centers," *New York Times*, July 17, 1988.

[42] Lerner.

[43] Ibid.

[44] Ibid.

[45] Ted Price and Richard Vitolo, "The Schooling of Incarcerated Young People," *Education Week*, June 15, 1988.

[46] This same testimony described the incidence of violence against instructors, further consequences and reminders of the volatile environments and sometimes violent individuals involved.

[47] These data are for male wards only. The data on arrests by gender, as well as many historical and contemporary studies, underscore the gendering of types of crime *and* the differing, gendered criteria of delinquency. For example, girls are still most likely to enter the system on charges related to status offenses that reflect infractions of social and moral codes regarding sexuality and sexual behavior. Varied histories of delinquency and the origins of girls' reformatories document practices from the turn of the century and before that corroborate this disproportionate regulation of girls through the juvenile justice system.

[48] For a helpful review of these varied lines of argument and research—biological, psychodynamic, sociological—see Krisberg and Austin. This book also provides so-called critical perspectives, the product of the New Criminology literature of the 1960s and 1970s, that outline the socially constructed nature of delinquency and its consequences, as well as note the location of the juvenile justice system within political and economic processes. For an insightful and provocative discussion of strengths, weaknesses, and consequences of official statistics on juvenile justice that this book and others use to analyze the system, see Cicourel and Kitsuse (1963).

[49] CYA, 1987.

[50] Richard J. Margolis, "Our Closet Youth Institutions," *New Leader*, March 21, 1988.

[51] For a review of the literature that finds "contrary to early claims that nothing works, cumulative evidence shows positive treatment effects of modest but not trivial magnitude," see Mark W. Lipsey, "Juvenile Delinquency Intervention," in H. S. Bloom, D. S. Cordray, and R. J. Light (eds.), *New Directions for Program Evaluation: Lessons from Selected Program and Policy Areas* (San Francisco: Jossey-Bass, 1988).

[52] "The Case Against Prisons for Profit," *Youth Policy* 10, no. 4 (April–May 1988).

[53] Los Angeles County reported 387 gang-related killings in 1987, substantially up from recent years.

[54] See "Big-City Gang Culture Spreading to New Turf," *Education Week* 7, no. 30, April 20, 1988.

[55] Lerner, 1986.

[56] Gina Cattalini, "Youth Gangs: Breaking the Cycle of Failure," in *Youth Policy* 10, no. 4, April/May 1988.

[57] Audrey James Schwartz, "Youth Gangs and High Schools in the Communities of East Los Angeles County," paper presented at the Sociology of Education conference, Asilomar, California, February 1988.

[58] Ibid.

[59] DYA, 1985.

[60] Department of the Youth Authority (DYA), Office of Criminal Justice Planning (1985), *Runaway and Homeless Youth: Proceeding of a Transfer of Knowledge Workshop* (Sacramento, CA: Department of Youth Authority, 1985).

[61] We note (along with many other analysts and commentators) that recent media, political, and scholarly attention to issues of child abuse underscore the existence of such incidents, but existing data in no way enable conclusions about changes in the incidence of such activities.

[62] CHS, 1984; DHS, 1988.

[63] Even though homicides are always coded as the underlying cause of death regardless of other causes of death listed on the death certificate, it is believed that homicides are underreported and some are misreported as "accidents." The extent of this underreporting or misreporting is unknown.

Other data sources: Department of Justice, State of California, Bureau of Criminal Statistics and Special Services (1987) *Homicide in California, 1986* (Sacramento: 1987).

[64] Peter Greenwood, A. Lipson, A. Abrahams, and F. Zimring, *Youth Crime and Juvenile Justice in California* (Santa Monica, CA: Rand Corporation, 1983).

Chapter 12

[1] Los Angeles Roundtable for Children 1986, *The Children's Budget of Los Angeles County Government* (Los Angeles: Los Angeles Roundtable for Children, 1986).

[2] J. Brown, "Hunger in the United States," *Scientific American* 2:37–41 (1987).

[3] I. Shapiro and R. Greenstein, *Holes in the Safety Nets, Poverty Programs and Policies in the States: California, A State Analysis* (Washington, D.C.: Center on Budget and Policy Priorities, 1988).

[4] California Legislative Analyst, *Public Assistance in California: Facts and Figures* (Sacramento: California Legislative Analyst, 1984).

[5] U.S. House of Representatives Select Committee on Children, Youth and Families, *Safety Net Programs: Are They Reaching Poor Children?* (Washington, DC: U.S. Government Printing Office, 1986).

[6] Shapiro and Greenstein.

[7] U.S. House of Representatives Committee on Ways and Means, 1987.

[8] U.S. Senate Committee on Finance, *Data and Materials Related to Welfare Programs for Families with Children* (Washington, DC: U.S. Government Printing Office, 1987).

[9] Ibid.

[10] J. Richardson, *Food Stamps: 1987 Issues* (Washington, DC: Congressional Research Service, 1987).

[11] U.S. House of Representatives Committee on Ways and Means, *Children in Poverty* (Washington, DC: U.S. Government Printing Office, 1985).

[12] S. House and S. Stephan, *Federal Programs Affecting Children* (Washington, DC: Congressional Research Service, 1987); V. Burke, *Welfare* (Washington, DC: Congressional Research Service, 1987).

[13] T. Joe and L. Potter, "The Welfare System: A Briar Patch for Anna Burns," *Public Welfare* 431:4–12 (1985).

[14] House and Stephan; U.S. House of Representatives Committee on Ways and Means, *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means* (Washington, DC: U.S. Government Printing Office, 1987).

[15] S. Stephan, *Child Welfare, Foster Care and Related Programs Under Titles IV-B and IV-E of the Social Security Act* (Washington, DC: Congressional Research Service, 1987).

[16] U.S. Senate Committee on Finance (1987).

[17] U.S. House of Representatives Committee on Ways and Means (1987); U.S. Senate Committee on Finance (1987).

[18] U.S. House of Representatives Select Committee on Children, Youth and Families (1987).

[19] Information compiled primarily from AFDC surveys of the California Department of Social Services from 1979 to 1986.

[20] Shapiro and Greenstein (1988).

[21] U.S. Senate Committee on Finance (1987).

[22] G. Waldinger, "Children on Welfare in Los Angeles County, a Profile of the Children of Federally-Aided Adults," *Networker* 92:4–6 (1988).

[23] California Department of Social Services (1986).

[24] U.S. General Accounting Office, *U.S. Child Support: Needed Efforts Underway to Increase Collections from Absent Parents* (Washington, DC: U.S. Government Printing Office, 1984).

[25] U.S. Senate Committee on Finance (1987).

[26] House and Stephan (1987).

[27] I. Garfinkel, "The Evolution of Child Support Policy," *Focus* 11:11–16 (1988).

[28] U.S. Department of Health and Human Services, *Child Support: A State-by-State Review* (Washington, DC: Office of Child Support Enforcement, 1984).

[29] C. Solomon, *Statistical Program Data in Single-Parent Families with Children* (Washington, DC: Congressional Research Service, 1986).

[30] P. Robins and K. Dickinson, "Receipt of Child Support by Single-Parent Families," *Social Service Review* 58:622–641 (1984).

[31] L. Weitzman, "Child Support Myths and Realities," in A. Kahn and S. Kammerman (eds.), *Child Support from Debt Collection to Social Policy* (Beverly Hills, CA: Sage, 1987).

[32] P. Robins, "Child Support, Welfare Dependency and Poverty, *American Economic Review* 76:768–788 (1986).

[33] Garfinkel (1988).

[34] California Senate Office of Research, *California State Senate 1987 Legislative Highlights, Children and Family Issues* (Sacramento: Senate Office of Research, 1987).

[35] U.S. Senate Committee on Finance (1987).

[36] California Legislative Analyst, *A Review of California's Child Support Enforcement Program* (Sacramento: California Legislative Analyst, 1985).

[37] U.S. House of Representatives Committee on Ways and Means (1987).

[38] California Legislative Analyst (1985); U.S. Department of Health and Human Services, Summaries of Reports by State Commissions on Child Support Enforcement (Washington, DC: Office of Child Support Enforcement, 1986).

[39] California Department of Social Services, Child Support Management Information System (monthly and annual reports), (Sacramento: Department of Social Services) 1978–79 through 1984–85.

[40] Garfinkel (1988).

[41] I. Garfinkel and S. McLanahan, *Single Mothers and Their Children, a New American Dilemma* (Washington, DC: Urban Institute Press, 1986).

[42] N. Goodban, "The Psychological Impact of Being on Welfare," *Social Service Review* 593:403–422 (1985).

[43] C. Longfellow and D. Belle, "Stressful Environments and Their Impact on Children," in J. Humphrey (ed.), *Stress in Childhood* (New York: AMS Press, 1984).

[44] D. Belle et al., "Depression and Low-Income Female-Headed Families," in E. Corfman (ed.,) *Families Today*, Vol. 1: *A Research Sampler on Families and Children* (Washington, DC: National Institute of Mental Health, 1981).

[45] E. Werner, "Individual Differences, Universal Needs: A 30-Year Study of Resilient High-Risk Infants," *Zero to Three* 84:1–5 (1988); N. Garmezy, "Stress, Competence, and Development: Continuities in the Study of Schizophrenic Adults, Children Vulnerable to Psychopathology and the Search for Stress-Resistant Children," *American Journal of Orthopsychiatry* 572:159–174 (1987); E. Anthony and B. Cohle (eds.), *The Invulnerable Child* (New York: Guilford Press, 1987).

[46] R. Seifer and A. Sameroff, "Multiple Determinants of Risk and Invulnerability," in E. Anthony and B. Cohler (eds.), *The Invulnerable Child* (New York: Guilford Press, 1987).

[47] S. McLanahan, "Family Structure and the Reproduction of Poverty," *American Journal of Sociology* 904:873–901 (1985).

[48] F. Furstenberg, J. Brooks-Gunn, and S. Morgan, *Adolescent Mothers in Later Life* (Cambridge, England: Cambridge University Press, 1987).

[49] I. Sawhill, "Anti-Poverty Strategies for the Next Decade," in B. Hinemand et al., *Work and Welfare, the Case for New Directions in National Policy* (Washington, DC: Center for National Policy, 1987).

[50] Furstenberg, Brooks-Gunn, and Morgan (1987).

[51] S. Chambre, "Tole Orientations and Intergenerational Welfare Use," *Social Casework* 661:13–20 (1985).

[52] G. Duncan, M. Hill, and S. Hoffman, "Welfare Dependence Within and Across Generation," *Science* 239:467–471 (1988).

[53] G. Cain and D. Wissoker, "Do Income Maintenance Programs Break Up Marriages? A Reevaluation of SIME-DIME," *Focus* 104:1–15 (1987–88).

[54] J. Lopez, "Welfare Reform," presentation to Los Angeles Roundtable for Children April 20, 1988.

[55] M. Abramovitz, *Regulating the Lives of Women, Social Welfare Policy from Colonial Times to the Present* (Boston: South End Press, 1988).

[56] U.S. General Accounting Office, *Work and Welfare: Current AFDC Work Programs and Implications for Federal Policy* (Washington, DC: U.S. Government Printing Office, 1987).

[57] Ibid.

[58] Manpower Development Research Corporation (MDRC), *The Demonstration of State Work/Welfare Initiatives: Findings from the San Diego Job Search and Work Experience Demonstration* (New York: MDRC, 1985); MDRC, *Final Report on the San Diego Job Search Work Experience Demonstration* (New York: MDRC, 1986); MDRC, *Work Initiatives for Welfare Recipients: Lessons from a Multi-State Experiment* (New York: MDRC, 1986).

[59] J. Gueron, "Work-Welfare Programs, Lessons from Selected Programs and Policy Areas," in E. Bloom, D. Cordray, and R. Light (eds.), *New Directions for Program Evaluation* (San Francisco: Jossey-Bass, 1988).

[60] M. Wiseman, "Workfare and Welfare Policy," *Focus* 93:1–8 (1986).

[61] Congressional Budget Office, *Work Related Programs for Welfare Recipients* (Washington, DC: Congressional Budget Office, 1987).

[62] Lopez (1988).

[63] J. Wallace and D. Long, *GAIN: Planning and Early Implementation* (New York: Manpower Development Research Corporation, 1987).

[64] Los Angeles Roundtable for Children (1986).

[65] J. Handler, "Consensus on Redirection—Which Direction?" *Focus* 111:29–34 (1988).

[66] Duncan, Hill, and Hoffman (1988).

Chapter 13

[1] These cases are derived from Laura Grandin and Jamie Halpern, *City and County of San Francisco Children, Youth, and Family Service System Feasibility Study*, study presented to the Mayor's Task Force on Dependent Children, San Francisco, December 15, 1987.

[2] See the PACE paper by Michael Kirst and Paul Goren, *An Exploration of County Expenditures and Revenues for Children's Services* (Berkeley, CA: Policy Analysis for California Education, 1988).

[3] The Little Hoover Commission, State Government Commission on California Organization and Economy, *The Children's Services Delivery System in California, Final Report*, October 1987.

[4] Grandin and Halpern, 1987, pp. 6-16. Also see Los Angeles County Children's Roundtable, *Report of the Children's Budget Implementation Committee* (Los Angeles: Los Angeles County Children's Roundtable, 1987).

[5] Los Angeles County Children's Roundtable.

[6] See Citizens Policy Center, *Lost in the Shuffle: A Report on the Guidance System in California Secondary Schools* (Santa Barbara, CA: Citizens Policy Center, 1979).

[7] Grandin and Halpern.

[8] Panel on Secondary School Education for the Changing Workplace, "High Schools and the Changing Workplace– the Employers' View," report of the Panel on Secondary School Education for the Changing Workplace (Washington, DC: National Academy Press, 1984). See also Allen Odden, "The California Economy 2010 and New Education Policies," a report prepared for the California Economic Development Council, California Governor's Office, 1988.

[9] Institute for Urban and Minority Education. S. K. Boardman, C. Harrington, and S. V. Horowitz, "Successful Women: A Psychological Investigation of Family Class and Education Origins," in Laurie Larwood and B.A. Gutek (eds.), *Women's Career Development* (Beverly Hills, CA: Sage, 1987).

[10] The Little Hoover Commission.

[11] Committee on Child Development Research and Public Policy, *Services for Children: An Agenda for Research* (Washington, DC: National Academy Press, 1981).

[12] Ventura County, *A Report and Commentary on the Ventura Model for Children's Mental Health Services* (Ventura, CA: Ventura County, 1987). See also San Bernardino County Children's Network *Program Description* (San Bernardino, CA: San Bernardino County, 1985).

[13] Minneapolis Youth Coordinating Board (MYCB), *Executive Summary* (Minneapolis: MYCB, 1987).

[14] Grandin and Halpern.

[15] Ventura County.

[16] See Lisbeth B. Schorr, *Within Our Reach: Breaking the Cycle of Disadvantage* (New York: Doubleday, 1988). See also William T. Grant Foundation Commission on Work, Family, and Citizenship, *The Forgotten Half* (Washington, DC: William T. Grant Foundation, 1988).

Chapter 14

[1] Paul Goren and Michael Kirst, *An Exploration of County Expenditure and Revenues for Children's Services*, forthcoming from Policy Analysis for California Education (PACE), Berkeley.

[2] The 1987 Little Hoover Commission (Commission on California State Government Organization and Economy) report, *The Children's Service Delivery System in California*, found that nine separate state departments/organizations administer thirty-five programs that focus solely on homeless children, abused and neglected children, and children in need of child care. These findings were based on the commission's *Survey of State Agencies*, 1987.

[3] *Growing Up in the Seventies*, Assembly Office of Research, 1973; *Improvements Are Needed in Coordination of Services for Children and Youth in California*, Office of the Auditor General, 1978; *Master Plan for Children and Youth*, Office of Statewide Health Planning and Development, 1981; *Realigning State and County Responsibilities*, Assembly Office of Research, 1982; *The Children's Services Delivery System in California*, Commission on California State Government Organization and Economy, 1987.

[4] Assembly Office of Research, 1973.

[5] Assembly Office of Research, 1982.

[6] The Little Hoover Commission, 1987.

APPENDIX TABLE 2-1 County Child Population, Actual and Projected, 1985–1995

County	1985	1990
Alameda	298,930	319,550
Alpine	250	220
Amador	5,250	6,580
Butte	37,860	42,840
Calaveras	5,990	7,120
Colusa	4,280	5,140
Contra Costa	181,500	190,360
Del Norte	5,170	5,230
El Dorado	25,940	29,930
Fresno	175,910	199,160
Glenn	6,610	7,150
Humboldt	28,170	28,280
Imperial	35,910	40,490
Inyo	4,430	4,410
Kern	146,480	164,610
Kings	27,810	32,620
Lake	10,210	12,590
Lassen	6,080	6,120
Los Angeles	2,232,520	2,471,490
Madera	23,850	27,490
Marin	42,890	40,290
Mariposa	3,010	3,610
Mendocino	20,320	21,870
Merced	55,450	70,480
Modoc	2,530	2,620
Mono	2,270	2,340
Monterey	89,530	93,880
Napa	23,810	24,730
Nevada	15,680	18,300
Orange	544,170	577,410
Placer	35,180	40,440
Plumas	4,920	5,100
Riverside	222,470	269,400
Sacramento	232,050	256,830
San Benito	9,550	11,260
San Bernardino	323,420	379,260
San Diego	532,030	585,130
San Francisco	126,890	137,980
San Joaquin	123,930	149,280
San Luis Obispo	41,490	49,000
San Mateo	136,140	140,460
Santa Barbara	78,920	86,430
Santa Clara	359,380	369,010
Santa Cruz	52,580	59,570
Shasta	35,260	38,670
Sierra	810	810
Siskiyou	11,300	11,470
Solano	78,310	84,610
Sonoma	82,930	88,030
Stanislaus	88,960	99,630
Sutter	16,390	17,900
Tehama	11,550	13,400
Trinity	3,440	3,560
Tulare	91,160	105,450
Tuolumne	9,160	10,990
Ventura	171,920	181,770
Yolo	29,550	31,990
Yuba	15,990	16,700

SOURCE: State Department of Finance, Projections 1980–2020.

APPENDIX TABLE 2-2 Children as a Percentage of Total County Populations, 1985, and Projected 1990 and 1995 (in descending order according to 1990 percentages)

County	1985	1990	1995
Merced	34.5%	37.8%	38.9%
Imperial	33.9	34.0	34.0
Tulare	32.5	33.4	34.0
Kings	32.8	32.2	32.5
Fresno	30.5	31.7	32.4
Colusa	29.1	31.4	32.0
San Joaquin	29.7	30.9	31.6
Madera	31.3	30.8	30.5
San Benito	31.3	30.5	30.3
Kern	30.5	30.5	30.5
San Bernardino	29.8	29.6	29.5
Stanislaus	29.2	29.2	29.3
Yuba	29.5	29.0	29.4
Los Angeles	27.6	28.9	29.5
Glenn	28.5	28.8	28.7
Sutter	28.0	28.2	28.3
Ventura	28.6	27.4	27.0
Mendocino	27.5	27.2	27.0
Solano	28.5	27.0	26.7
Tehama	26.1	27.0	27.5
Riverside	27.1	26.9	27.4
Del Norte	27.5	26.6	25.8
Modoc	26.6	26.1	26.6
Shasta	26.8	26.1	26.1
Sacramento	26.0	25.9	26.1
Monterey	27.2	25.8	26.1
Siskiyou	26.4	25.8	25.5
Placer	25.4	25.4	25.7
Alameda	25.0	25.1	26.1
Orange	25.6%	25.1%	25.5%
Santa Cruz	24.5	24.8	25.5
Santa Clara	25.7	24.8	25.3
Contra Costa	25.3	24.8	25.1
Plumas	25.6	24.6	23.9
San Diego	25.0	24.5	25.1
Mono	24.4	24.4	25.3
El Dorado	24.8	24.3	24.2
Humboldt	24.9	24.2	23.6
Trinity	25.3	24.1	23.2
Yolo	23.8	23.9	23.9
Sonoma	24.7	23.8	23.9
Inyo	24.1	23.7	23.9
Santa Barbara	23.6	23.7	24.7
Butte	23.1	23.4	24.0
Lassen	24.7	23.2	22.3
Mariposa	22.4	22.9	24.1
Napa	22.9	22.4	23.1
Amador	22.4	22.2	22.9
Tuolumne	22.5	22.2	22.8
San Mateo	22.1	22.1	22.9
Calaveras	22.4	22.1	22.5
Nevada	23.0	22.0	22.2
Sierra	23.1	21.7	20.6
San Luis Obispo	21.8	21.4	22.0
Lake	21.1	21.1	22.0
San Francisco	17.3	17.8	18.7
Marin	19.0	17.5	17.9
Alpine	21.3	17.4	16.7

SOURCE: State Department of Finance, Projections 1980–2020.

APPENDIX TABLE 2-3 Counties with the Largest Projected Percentage Change in Child Population, by Age, 1985–1995

Ages 0–4				Ages 5–9			
1985–90		1990–95		1985–90		1990–95	
Mariposa	28%	Alpine	20%	Colusa	49%	Mariposa	43%
Calaveras	28	Calaveras	18	Riverside	44	Tuolumne	25
Tuolumne	27	Nevada	15	Kings	42	Calaveras	24
Lake	27	Lake	14	San Francisco	40	Amador	17
Amador	24	Tuolumne	12	Santa Cruz	40	Placer	16
Humboldt	–14	Los Angeles	–6	Merced	38	Humboldt	–14
Mono	–16	San Mateo	–7	San Luis Obispo	37	Mono	–16
Lassen	–16	Mono	–9	San Joaquin	36	Lassen	–18
Alpine	–22	Humboldt	–10	Lake	36	Alpine	–26
Sierra	–29	San Francisco	–16	Sutter	36	Sierra	–26

Ages 10–14				Ages 15–19			
1985–90		1990–95		1985–90		1990–95	
Merced	69%	Riverside	46%	Amador	40%	Merced	67%
Mariposa	52	San Francisco	45	Madera	15	Colusa	47
Colusa	42	Kings	42	Riverside	13	Mariposa	44
Fresno	31	San Luis Obispo	42	San Benito	13	Imperial	33
Imperial	29	Santa Cruz	40	San Joaquin	12	Fresno	32
Santa Clara	–6	Sutter	35	Modoc	–15	Trinity	–9
Napa	–6	Colusa	35	Alameda	–16	Alpine	–9
Monterey	–9	San Joaquin	33	San Mateo	–22	Napa	–9
Marin	–14	Alpine	32	Alpine	–25	Marin	–19
Alpine	–16	Mariposa	–7	Marin	–29	Placer	–89

SOURCE: State Department of Finance, Projections 1980–2020.

APPENDIX TABLE 3-1 Age-Specific Live Birthrates, California Counties, 1986 (Mothers Aged 15–19)

Alphabetical Order		Descending Order	
CALIFORNIA	53.2	Tulare	91.7
Alameda	37.5	Kings	90.8
Alpine	47.6	Merced	86.9
Amador	29.9	Kern	84.9
Butte	37.4	Yuba	82.3
Calaveras	35.4	Fresno	78.9
Colusa	61.9	San Joaquin	73.7
Contra Costa	36.9	Lake	71.1
Del Norte	66.5	Glenn	71.0
El Dorado	42.2	Madera	70.1
Fresno	78.9	Riverside	67.1
Glenn	71.0	Del Norte	66.5
Humboldt	43.3	Imperial	66.2
Imperial	66.2	Los Angeles	65.9
Inyo	41.9	San Bernardino	65.0
Kern	84.9	Stanislaus	63.7
Kings	90.8	San Benito	62.3
Lake	71.1	Colusa	61.9
Lassen	56.0	Monterey	61.1
Los Angeles	65.9	Mendocino	59.8
Madera	70.1	Modoc	59.5
Marin	8.8	Lassen	56.0
Mariposa	50.9	Sacramento	55.3
Mendocino	59.8	Solano	53.5
Merced	86.9	CALIFORNIA	53.2
Modoc	59.5	Mariposa	50.9
Mono	20.2	Tehama	50.7
Monterey	61.1	Shasta	50.7
Napa	31.4	Alpine	47.6
Nevada	26.7	Sutter	46.7
Orange	37.6	Siskiyou	45.3
Placer	30.5	San Diego	43.8
Plumas	34.7	San Francisco	43.6
Riverside	67.1	Humboldt	43.3
Sacramento	55.3	El Dorado	42.2
San Benito	62.3	Inyo	41.9
San Bernardino	65.0	Ventura	41.0
San Diego	43.8	Trinity	39.9
San Francisco	43.6	Santa Cruz	39.3
San Joaquin	73.7	Yolo	37.6
San Luis Obispo	28.8	Orange	37.6
San Mateo	26.8	Alameda	37.5
Santa Barbara	32.9	Butte	37.4
Santa Clara	35.1	Contra Costa	36.9
Santa Cruz	39.3	Calaveras	35.4
Shasta	50.7	Santa Clara	35.1
Sierra	0.0	Plumas	34.7
Siskiyou	46.3	Santa Barbara	32.9
Solano	53.5	Tuolumne	31.7
Sonoma	29.6	Napa	31.4
Stanislaus	63.7	Placer	30.5
Sutter	46.7	Amador	29.9
Tehama	50.7	Sonoma	29.6
Trinity	39.0	San Luis Obispo	28.8
Tulare	91.7	San Mateo	26.8
Tuolumne	31.7	Nevada	26.7
Ventura	41.0	Mono	20.2
Yolo	37.6	Marin	8.8
Yuba	82.3	Sierra	0.0

Note: An age-specific live birthrate is the number of live births per thousand women in a specific age group.

SOURCE: Brindis and Jeremy, *Adolescent Pregnancy and Parenting in California: A Strategic Plan for Action*, 1988.

APPENDIX TABLE 8-1 Live Births to Teenage Mothers, by Age of Father, California Counties, 1985

				Age of Father											
	Total	Total Under Age 20	Percent Under Age 20	<13	13	14	15	16	17	18	19	15–19	20–24	25+	Unknown
CALIFORNIA	51,255	14,376	28.00%	0	6	54	302	979	2,398	4,356	6,272	1,4307	2,5025	7,709	4154
Alameda	1,797	530	29.90	0	2	4	13	42	87	177	213	532	964	250	145
Alpine	1	0	0.00	0	0	0	0	0	0	0	0	0	1	0	0
Amador	27	6	22.20	0	0	0	0	0	2	1	3	6	12	5	4
Butte	294	67	22.80	0	0	0	3	2	11	16	35	67	153	38	36
Calaveras	38	12	31.60	0	0	0	0	0	0	4	8	12	16	7	3
Colusa	29	2	6.90	0	0	0	0	0	0	0	2	2	19	7	1
Contra Costa	919	267	29.10	0	0	3	9	21	36	77	121	264	435	141	76
Del Norte	46	12	26.10	0	0	0	0	1	0	3	8	12	26	4	4
El Dorado	138	27	19.60	0	0	0	0	2	3	11	11	27	77	15	19
Fresno	1,760	597	33.90	0	0	3	19	42	107	178	248	594	848	243	72
Glenn	50	10	20.00	0	0	0	0	0	1	1	8	10	25	12	3
Humboldt	169	32	18.90	0	0	0	0	0	4	7	21	32	80	35	22
Imperial	308	104	33.80	0	0	0	1	5	16	40	42	104	141	42	21
Inyo	17	2	11.80	0	0	0	1	0	0	0	1	2	8	2	5
Kern	1,552	436	28.10	0	1	2	5	36	73	122	197	433	790	196	130
Kings	292	93	31.80	0	0	0	4	2	16	31	40	93	143	37	19
Lake	106	16	15.10	0	0	0	0	0	3	5	8	16	62	21	7
Lassen	45	5	11.10	0	0	0	0	1	1	1	2	5	23	8	9
Los Angeles	18,100	5,203	28.70	0	1	19	101	360	907	1594	2221	5,183	8,710	3,038	1,149
Madera	224	70	31.20	0	0	1	1	4	16	23	25	69	113	28	13
Marin	64	16	25.00	0	0	1	0	1	4	3	7	15	24	12	12
Mariposa	15	1	6.70	0	0	0	0	0	0	1	0	1	8	3	3
Mendocino	144	24	16.70	0	0	0	0	1	3	5	15	24	76	25	19
Merced	534	140	26.20	0	0	1	2	6	22	44	65	139	271	75	48
Modoc	15	4	26.70	0	0	0	0	1	1	0	2	4	6	2	3
Mono	14	2	14.30	0	0	0	0	0	1	0	1	2	3	4	5
Monterey	748	200	25.50	0	0	1	4	14	26	59	96	199	448	91	45
Napa	117	29	24.80	0	0	0	0	1	9	9	10	29	63	20	5
Nevada	68	17	25.00	0	0	0	0	1	0	8	8	17	37	7	7
Orange	3,857	702	23.00%	0	0	0	11	40	94	215	342	702	1,522	544	289
Placer	176	41	23.30	0	0	0	1	1	7	13	19	41	90	18	27
Plumas	22	5	22.70	0	0	0	0	0	2	2	1	5	11	4	2
Riverside	1,931	574	29.70	0	0	2	12	35	98	186	241	572	936	252	169

(APPENDIX TABLE 8-1 continued on next page)

APPENDIX TABLE 8-1 Continued

	Total	Total Under Age 20	Percent Under Age 20	Age of Father											
				<13	13	14	15	16	17	18	19	15–19	20–24	25+	Unknown
Sacramento	1,875	594	31.70	0	0	2	17	45	91	181	258	592	850	226	2
San Benito	68	18	26.50	0	0	0	0	3	4	4	7	18	37	9	4
San Bernardino	2,746	862	31.40	0	1	0	20	57	161	251	372	861	1347	301	236
San Diego	3,536	911	25.60	0	0	2	21	60	138	267	423	909	1817	469	366
San Francisco	726	229	31.50	0	1	2	3	20	49	57	97	226	339	109	49
San Joaquin	1,108	308	27.80	0	0	3	5	17	54	98	131	305	538	144	118
San Luis Obispo	217	50	23.00	0	0	0	1	3	5	18	23	50	103	34	30
San Mateo	531	106	20.00	0	0	0	0	8	18	29	51	106	290	105	30
Santa Barbara	477	119	24.90	0	0	1	5	5	17	35	56	118	249	68	41
Santa Clara	2,096	623	29.70	0	0	2	16	49	101	194	261	621	912	316	245
Santa Cruz	339	65	19.20	0	0	0	2	5	6	23	29	65	169	69	36
Shasta	265	63	23.80	0	0	0	4	0	13	22	24	63	133	37	32
Sierra	5	0	0.00	0	0	0	0	0	0	0	0	0	3	1	1
Siskiyou	63	11	17.50	0	0	1	0	1	2	3	4	10	29	5	18
Solano	519	135	26.00	0	0	0	3	11	18	32	71	135	274	76	34
Sonoma	387	82	21.20	0	0	0	1	8	15	18	40	82	203	59	43
Stanislaus	780	245	31.40	0	0	3	4	12	39	82	105	242	373	106	56
Sutter	136	44	32.40	0	0	0	0	3	6	12	23	44	63	21	8
Tehama	75	17	22.70	0	0	0	0	0	1	7	9	17	41	9	8
Trinity	20	5	25.00	0	0	0	0	1	1	3	0	5	9	3	3
Tulare	937	241	25.70	0	0	1	3	23	45	71	98	240	461	141	94
Tuolumne	47	10	21.30	0	0	0	0	1	0	4	5	10	24	8	5
Ventura	1,038	283	27.30	0	0	0	6	23	52	83	119	283	517	154	84
Yolo	218	42	19.30	0	0	0	2	4	5	12	19	42	116	38	22
Yuba	166	50	30.10	0	0	0	2	1	7	14	26	50	87	15	14

SOURCE: California Department of Health Services,

APPENDIX 9-1

Intellectual Disorders. The only *DSM-III-R* mental disorder that involves primarily intellectual impairment is mental retardation, although intellectual features are often involved in other disorders. Mental retardation is defined as significantly subnormal intellectual ability (that is, 70 or below on a standardized intelligence test).

Developmental Disorders. Developmental disorders, resulting in major deviations from the normal path of development, can be either pervasive, affecting multiple areas of functioning, or specific, affecting only one aspect of development. The pervasive developmental disorders are characterized by qualitative impairment in the development of reciprocal social interaction, verbal and nonverbal communication skills, and imaginative ability. The specific developmental disorders are manifested by inadequate development of academic, language, speech, and motor skills, and are not associated with demonstrable physical or neurologic disorders or mental retardation.

Behavior Disorders. This broad category includes disorders characterized by behavior that is socially disruptive and often more distressing to others than to the afflicted; for example, attention deficit disorder, oppositional defiant disorder, and conduct disorder. In the clinical and research literature, the behaviors these disorders encompass have been referred to as "externalizing" symptoms.

Emotional Disorders. Anxiety disorders, phobias, depressive symptoms, and reactive attachment disorder of infancy are disorders characterized by emotional states that interfere with the child's ability to function. Anxiety disorders that are especially associated with childhood include separation anxiety disorder, avoidant disorder of childhood, overanxious disorder, and certain phobias. These disorders are characterized by excessive fearfulness that interferes with a child's ability to participate in normal activities.

"Depression" can refer to a mood, a set of symptoms that occur together, or to a complete psychiatric disorder with characteristic symptoms, course, and prognosis. It influences concentration, energy level, and confidence. Serious depression can affect physical health, and has the potential to seriously impair a child's normal activities and functioning with family and pers. Depressed children commonly withdraw from social relationships. Depressed adolescents may react with sulky, angry, or aggressive behavior, problems in school, or substance abuse.

Reactive attachment disorder of infancy, in severe cases called "failure to thrive," results in poor emotional and physical development. If the disorder is not treated, it often results in severe physical complications.

Psychophysiological Disorders. Children's mental disorders that involve a disturbance in some aspect of bodily functioning usually involve a combination of mental and physical factors. Included are stereotyped movement disorders, enuresis, encopresis, and eating disorders. These disorders have in common the fact that they may place children at great risk since they pose threats to both physical and mental health.

Other DSM Categories. Other *DSM-III-R* categories that are often appropriate for children and adolescents include organic mental disorders, substance use disorders, psychosexual disorders, personality disorders, mood disorders, and adjustment disorders. Adjustment disorders are unlike most *DSM-III-R* disorders in that a specific stressful event is considered to be the cause. Adjustment disorder refers to a pattern of emotional or behavioral difficulties that occurs in response to stressful event, such as divorce or acute illness of parent. The term "adjustment disorders" often remit without treatment, either because the stressful event has ended or because the child and family have developed new resources for responding to the situation. The main features of adjustment disorder are depressed or anxious moods, antisocial behavior, difficulites in infant-parent interaction, or inability to maintain relationships or to work.

Mood disorders, called "affective disorders" in *DSM-III*, refer to the diagnostic classifications for the complete psychiatric disorders commonly called "depression," including bipolar disorder, cyclothymia, major depression, and dysthymia. The essential feature of this group of disorders is a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. The term "mood" refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The following children's mental disorders are listed in the *DSM-III-R:*

MENTAL DISORDERS THAT ARE USUALLY FIRST EVIDENT IN INFANCY, CHILDHOOD, OR ADOLESCENCE

Intellectual Disorders

Mental retardation

Mild mental retardation, moderate retardation, severe mental retardation, unspecified mental retardation

Developmental Disorders

Pervasive developmental disorders (PDDs)

Infantile autism (onset before 30 months of age), childhood-onset pervasive developmental disorder (onset after 30 months of age and before 12 years of age)

Specific developmental disorders (SDDs) (Axis II of DSM-III)

Developmental reading disorder (dyslexia), developmental arithmetic disorder, developmental language disorder (expressive type or receptive type), developmental articulation disorder, mixed specific developmental disorder, atypical specific developmental disorder

Behavior Disorders

Attention deficit disorder (ADD)

ADD with hyperactivity, ADD without hyperactivity

Conduct disorder

Undersocialized, aggressive; undersocialized, nonaggressive; socialized, aggressive; socialized, nonaggressive; atypical

Emotional Disorders

Anxiety disorders of childhood or adolescence

Separation anxiety disorder; avoidant disorder of childhood or adolescence; overanxious disorder

Other disorders of infancy, childhood, or adolescence

Reactive attachment disorder of infancy; schizoid disorder of childhood or adolescence; elective mutism; oppositional disorder; identity disorder

Physical (Psychophysiological) Disorders

Stereotyped movement disorders

Transient tic disorder, chronic motor tic disorder, Tourette's disorder, atypical tic disorder, atypical stereotyped movement disorder

Eating disorders

Anorexia nervosa, bulimia, pica

Other disorders with physical manifestations

Stuttering enuresis (repeated involuntary voiding of urine), encopresis (repeated voluntary or involuntary defecation in inappropriate places), sleepwalking disorder, sleep terror disorder

Other Mental Disorders That May Affect Children

Organic mental disorders (such as delirium, dementia, alcohol intoxication, barbiturate intoxication)

Substance use disorders – sometimes occur in teens
- Abuse of or dependence on any of five classes of substances; alcohol, barbiturates, opiods, amphetamines, and cannabis
- Abuse of any of three classes of substances; cocaine, phencyclidine (PCP), and hallucinogens
- Dependence on tobacco
- Other, mixed, or unspecified substance abuse (such as glue sniffing)
- Dependence on a combination of substances (such as heroin and barbiturates, amphetamines and barbiturates)

Schizophrenic disorders (such as disorganized, catatonic, paranoid, or undifferentiated type) – onset is usually in late adolescence or early adulthood

Schizophreniform disorder

Affective disorders
- Major depression (single episode, recurrent) – can occur at any age, including infancy

Anxiety disorders
- Phobic disorders:
  - Social phobia – often begins in late childhood or early adolescence
  - Simple phobia (such as of animals, heights, school, water) – age at onset varies, but fear of animals almost always begins in childhood
- Anxiety states:
  - Panic disorder – often begins in late adolescence
  - Generalized anxiety disorder
  - Obsessive compulsive disorder – usually beings in adolescence or early adulthood, but may begin in childhood
  - post traumatic stress disorder – can occur at any age

Somatoform disorders (such as somatization disorder, conversion disorder, psychogenic pain disorder, hypocondriasis)

Psychosexual disorders
- Gender identity disorders:
  - Transsexualism
  - Gender identity disorder of childhood
  - Paraphilias (such as exhibitionism, sexual masochism)
  - Other psychosexual disorders (such as ego-dystonic homosexuality)

Factitious disorders

Disorders of impulse control not elsewhere classified (such as kleptomania, pyromania)

Adjustment disorder – may begin at any age

Personality disorders (Axis II of *DSM-III*)

Although the symptoms of personality disorders may manifest themselves in adolescence or earlier, the diagnosis of a personality disorder (such as paranoid personality disorder, schizoid personality disorder, histrionic personality disorder, antisocial personality disorder) is generally reserved for adults. Some personality disorders in adults have a relationship to corresponding diagnostic categories for children or adolescents:

Disorders of childhood	*Personality disorders*
Schizoid disorder of childhood	Schizoid personality disorder
Avoidant disorder of childhood	Avoidant personality disorder
Conduct disorder (undersocialized, aggressive)	Antisocial personality disorder
Oppositional disorder	Passive-aggressive personality disorder
Identity disorder	Borderline personality disorder

APPENDIX 9-2 POLICY IMPLICATIONS

A variety of federal and state legislation contains appropriate recommendations for the identification and treatment of children's mental health problems. In particular, the NIMH Child and Adolescent Service System Program (CASSP) developed criteria for the definition of emotionally disturbed children and recommendations for providing care. CASSP recommends that steps must be taken to (1) identify service gaps and barriers, (2) develop service options, (3) develop systems at the community level, and (4) overcome barriers by changing legislation and funding requirements.

There is no lack of recommendations for improving the system of identification and care of mentally ill children. Putting these policies into practice has been problematic, however. Several of these recommendations are being addressed in California through specific state, county, and local programs; but communication, dissemination and replication of these approaches have had limited success. The following are recommendations for improving policy implementation:

Recommendation #1. Integrate programs on federal, state, county, and local levels to provide a cohesive approach to children's mental health. Acknowledge the need for comprehensive services—prevention, early identification, diagnosis, treatment, and rehabilitation—provided by the mental health system as well as by medical, educational, child welfare, and juvenile justice systems.

Recommendation #2. Improve California's database of statistics on children's mental health problems to provide sound basis for policy.[4] Overall, the need is for a coherent body of information about mental health problems, including (1) distribution in the population, (2) family demographics, (3) life circumstances, and (4) the development, health, and behavior of children and adolescents themselves. All this information should be collected with the child and family (rather than the problem occurrence, or the service delivery episode) as the unit of observation.[5]

- State agencies are a primary source of information on children and families. Interagency coordination and cooperation, with respect to child and family statistics, should be fostered at both the local and the state levels.[6]
- Public and private agencies should link informational networks as a cost-effective way to expand the database on mental health problems and to include the full range of available services. Currently, there are no systematic data links between the public sector and private treatment sources.
- The state of California should consider designing a state survey modeled after the National Health Interview Survey so that population-based data would be available to guide policy formation.

Recommendation #3. Evaluate the effectiveness of current models of care, operationalize these models, and provide technical assistance to translate and disseminate these models to other settings:

- Family-based models of care
- Continuum of service models
- Crisis intervention services
- Integrated case management services
- Specialized foster family homes
- Adolescent group homes
- Respite services and in-home treatment services
- Therapeutic nurseries.

Recommendation #4. Develop new models of care that provide maximum integration of services and support children in the context of their families.

Recommendation #5. Develop and implement prevention programs in preschool, day care, the schools, and community social programs for families, through self-help groups. Such prevention should provide a continuum of services aimed at supporting children and families and addressing high-risk situations.

Recommendation #6. · Provide education services through professional mental health consultations in all settings that may improve early identification of disturbed children: preschools, day care, schools, social service agencies, juvenile justice agencies, medical settings, and the like.

Recommendation #7. Provide professional training to increase sensitivity to children's mental health needs among teachers, day care workers, physicians and other medical personnel, parents, foster parents, and social service and juvenile justice workers.

Recommendation #8. Examine the cultural appropriateness of mental health services and develop approaches that will address the perceptions of mental health issues among a number of cultural and ethnic populations.

Recommendation #9. Provide case management resources to coordinate and integrate services for children across systems.

Recommendation #10. Improve Medicaid access and reimbursement for early identification, prevention, diagnostic, treatment, and case management services.

Recommendation #11. Improve the CHDP program for developmental screening, assessment, and referral. Needed improvements include better monitoring of developmental problems as well as coordination of services with mental health and child welfare agencies.

Recommendation #12. Provide assistance to legislators concerning effective models of care and funding mechanisms.

Recommendation #13. Improve diagnostic approaches and develop case management for appropriate referrals and follow-up. The development of minimum assessment protocols for specific subpopulations of mentally ill and potentially mentally ill children is essential. Such minimum assessment and treatment protocols should also be implemented in all counties for children in out-of-home care.

Recommendation #14. Provide all of the preceding services—prevention, early identification, diagnosis, treatment, rehabilitation, and case management services—to all children in or out of home care.

APPENDIX TABLE 10-1 Child Abuse Report Rates: Involved Children per 1,000 U.S. Children, Ranked by State[a]

	1982	Rank	1983	Rank	1984	Rank	1985	Rank
National	20.1	—	23.6	—	27.3	—	30.6	—
Alabama	21.24	19	21.04	23	25.59	27	28.10	28
Alaska	22.55	18	32.45	9	43.53	5	47.27	4
Arizona	n.a.	—	n.a.	—	23.12	31	45.42	7
Arkansas	23.34	17	25.89	18	32.17	18	31.09	25
CALIFORNIA	**33.71**	**5**	**35.24**	**6**	**37.57**	**7[b]**	**43.24**	**10**
Colorado	n.a.	—	n.a.	—	15.67	45	15.52	48
Connecticut	15.51	31	18.55	29	22.78	32	22.23	41
Delaware	n.a.	—	52.66	1	50.88	2	38.95	13
D.C.	39.74	2	49.27	2	28.94	23	45.38	8
Florida	33.25	6	39.33	4	34.88	12	55.25	3
Georgia	18.61	26	21.70	21	22.20	35	25.74	31
Hawaii	10.78	34	11.21	38	13.84	46	14.03	50
Idaho	20.00	22	n.a.	—	35.30	10	39.16	12
Illinois	19.58	23	20.55	24	21.70	39	22.47	40
Indiana	15.53	30	18.20	30	19.15	42	22.49	39
Iowa	28.14	11	29.52	15	31.95	19	33.03	23
Kansas	29.65	8	32.70	8	35.01	11	35.48	17
Kentucky	29.23	9	31.50	12	31.76	20	34.30	20
Louisiana	28.10	12	24.61	19	25.65	26	35.79	16
Maine	28.06	13	38.54	5	44.20	4	30.97	26
Maryland	n.a.	—	13.30	36	7.44	49	17.36	46
Massachusetts	20.40	20	26.31	17	33.99	13	34.50	18
Michigan	32.10	7	34.33	7	36.45	9	38.31	14
Minnesota	12.63	33	14.36	34	21.08	40	19.36	43
Mississippi	n.a.	—	n.a.	—	8.74	48	16.41	47
Missouri	42.26	1	49.08	3	55.13	1	57.24	1
Montana	18.80	25	18.56	28	21.72	38	43.77	9
Nebraska	13.32	32	12.29	37	18.58	43	28.58	27
Nevada	36.07	4	32.01	10	37.59	6	55.92	2
New Hampshire	n.a.	—	n.a.	—	26.62	24	23.96	35
New Jersey	10.06	35	14.12	35	23.94	29	25.31	33
New Mexico	n.a.	—	n.a.	—	32.18	17	25.49	32
New York	n.a.	—	21.72	20	30.69	21	31.83	24
North Carolina	16.84	27	17.00	31	16.38	44	17.39	45
North Dakota	19.37	24	19.32	26	22.38	34	23.95	36
Ohio	n.a.	—	n.a.	—	32.87	15	22.96	37
Oklahoma	16.66	28	16.50	33	19.71	41	21.94	42
Oregon	n.a.	—	n.a.	—	23.33	30	41.72	11
Pennsylvania	5.22	37	5.39	40	6.90	50	7.29	51
Rhode Island	n.a.	—	n.a.	—	37.57	7[b]	46.28	5
South Carolina	25.45	15	16.75	32	25.84	25	24.22	34
South Dakota	25.24	16	27.34	16	49.25	3	45.82	6
Tennessee	25.83	14	29.70	14	32.98	14	38.22	15
Texas	20.21	21	21.35	22	22.45	33	22.63	38
Utah	n.a.	—	n.a.	—	23.95	28	27.53	29
Vermont	n.a.	—	18.91	27	22.13	36	26.95	30
Virginia	28.23	10	30.09	13	30.00	22	34.46	19
Washington	36.43	3	31.98	11	36.51	8	33.90	21
West Virginia	n.a.	—	n.a.	—	32.69	16	33.64	22
Wisconsin	6.90	36	7.46	39	13.47	47	19.01	44
Wyoming	16.30	29	20.30	25	21.89	37	14.49	49
States	37		40		51		51	
Ranks	nos. 1–37		nos. 1–40		nos. 1–50		nos. 1–51	
Rate range	42.26–5.22		52.66–5.39		55.13–6.90		57.24–7.29	

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[a] Includes District of Columbia

[b] Two or more states share the same rank.

SOURCE: American Humane Association, *Highlights of Official Child Neglect and Abuse Reporting*, 1985 (Denver: American Humane Association, 1987).

APPENDIX TABLE 10-2 Child Abuse and Neglect Reporting Rates, Annual Percent Change and Rank of Percent Change, 1983–1986, by State

	1983–84		1984–85		1985–86	
	% Change	Rank	% Change	Rank	% Change	Rank
Alabama	21%	10[a]	10%	15[a]	—	—
Alaska	—	—	5	20[a]	20%	2[a]
Arizona	29	7	23	8	12	6
Arkansas	20	11[a]	—	—	8	10[a]
CALIFORNIA	**7**	**23[a]**	**18**	**11**	**20**	**2[A]**
Colorado	10	20[a]	–8	27	—	—
Connecticut	11	19	1	22[a]	—	—
Delaware	—	—	–17	28	10	8[a]
D.C.	—	—	–1	23[a]	21	1
Florida	27	8	15	13	9	9[a]
Georgia	10	20[a]	17	12[a]	17	3
Hawaii	10	20[a]	–3	24	1	16[a]
Idaho	14	17	7	18[a]	2	15
Illinois	9	21[a]	4	21[a]	1	16[a]
Indiana	12	18	21	9	–1	18
Iowa	—	—	1	22[a]	8	10[a]
Kansas	9	21[a]	9	16[a]	–9	21
Kentucky	65	2	6	19[a]	6	12[a]
Louisiana	7	23[a]	36	4	–6	20
Maine	16	15	8	17[a]	5	13[a]
Maryland	17	14[a]	—	—	—	—
Massachusetts	19	12	6	19[a]	5	13[a]
Michigan	5	25[a]	8	17[a]	—	—
Minnesota	—	—	–6	26	–23	23
Mississippi	—	—	64	1	13	5
Missouri	18	13[a]	5	20[a]	1	16[a]
Montana	10	20[a]	7	18[a]	—	—
Nebraska	41	5	30	6	–2	19
Nevada	15	16[a]	8	17[a]	11	7
New Hampshire	20	11[a]	–5	25[a]	—	—
New Jersey	—	—	20	10[a]	—	—
New Mexico	6	24[a]	26	7	—	—
New York	9	21[a]	4	21[a]	14	4
North Carolina	6	24[a]	5	20[a]	—	—
North Dakota	24	9	5	20[a]	6	12[a]
Ohio	40	6	35	5	6	12[a]
Oklahoma	21	10[a]	12	14	9	9[a]
Oregon	48	3	10	15[a]	7	11
Pennsylvania	7	23[a]	4	21[a]	10	8[a]

(APPENDIX TABLE 10-2 continued on next page)

APPENDIX TABLE 10-2 Continued

	1983–84		1984–85		1985–86	
	% Change	Rank	% Change	Rank	% Change	Rank
Rhode Island	190	1	—	—	–13	22
South Carolina	—	—	9	16[a]	0	17
South Dakota	17	14[a]	39	3	9	9[a]
Tennessee	18	13[a]	—	—	—	—
Texas	8	22	4	21[a]	—	—
Utah	1	26	17	12[a]	3	14
Vermont	15	16[a]	20	10[a]	—	—
Virginia	6	24[a]	4	21[a]	—	—
Washington	5	25[a]	–5	25[a]	9	9[a]
West Virginia	—	—	—	—	—	—
Wisconsin	45	4	46	2	10	8[a]
Wyoming	18	13[a]	–1	23[a]	—	—
Average increase	22%		12%		6%	
Number of states	42		46		35	
Ranks	nos. 1–26		nos. 1–28		nos. 1–23	
Rate range	190% to 1%		64% to –17%		21% to –23%	

[a] Two or more states share the same rank

SOURCE: National Committee for the Prevention of Child Abuse.

APPENDIX TABLE 10-3 Emergency Response Inquiries Received and Subsequent Action, January–December 1986, by County, in California

County	No. of Inquiries	(%) Inquiry Rate	Inquiry Rank	Closed—No Action	(%) CNA Rate	To FM	(%) FM Rate	To Reun.	(%) Reun. Rate	To PP	(%) PP Rate
Totals	341,756	4.9%	—	253,383	74%	52,455	15%	18,581	5%	735	0.2%
Alameda	9,978	3.4	33[a]	6,544	66	2,691	27	740	7	42	0.4
Alpine	16	5.2	25	8	50	6	38	4	25	1	6
Amador	160	3.1	36[a]	131	82	9	6	8	5	0	0
Butte	3,315	9.1	5[a]	2,464	74	484	15	198	6	1	0.03
Calaveras	397	6.4	17[a]	284	72	60	15	29	7	4	1
Colusa	301	7.4	12[a]	273	91	21	7	14	5	0	0
Contra Costa	7,822	4.1	31	6,681	85	657	8	376	5	7	0.1
Del Norte	722	13.8	1	531	74	104	14	32	4	3	0.4
El Dorado	852	3.3	34	579	68	106	12	51	6	11	1
Fresno	15,879	9.4	4	13,509	85	1,648	10	470	3	64	0.4
Glenn	353	5.3	24	292	83	27	8	3	0.8	0	0
Humboldt	1,646	5.9	20[a]	1,374	83	112	7	65	4	9	0.6
Imperial	832	2.3	41	606	73	111	13	77	9	0	0
Inyo	267	5.7	22	169	63	32	12	18	7	1	0.4
Kern	9,357	6.6	16	8,040	86	601	6	445	5	1	0.01
Kings	1,305	4.8	27[a]	1,135	87	106	8	61	5	9	0.7
Lake	801	8.1	8[a]	729	91	42	5	25	3	0	0
Lassen	383	5.8	21	305	80	13	3	28	7	4	1
Los Angeles	103,118	4.8	27[a]	58,808	57	28,065	27	8,224	8	68	0.07
Madera	1,110	4.7	28[a]	761	69	65	6	32	3	2	0.2
Marin	924	1.8	42	700	76	178	19	52	6	1	0.1

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APPENDIX TABLE 10-3 Continued

County	No. of Inquiries	(%) Inquiry Rate	Inquiry Rank	Closed—No Action	(%) CNA Rate	To FM	(%) FM Rate	To Reun.	(%) Reun. Rate	To PP	(%) PP Rate
Mariposa	227	7.6	11[a]	179	79	19	8	6	3	0	0
Mendocino	1,479	7.3	13	1,169	79	125	8	69	5	1	0.07
Merced	3,994	8.1	8[a]	3,566	89	327	8	75	2	0	0
Modoc	244	8.9	6	183	75	34	14	15	6	0	0
Mono	103	4.7	28[a]	75	73	4	4	8	8	0	0
Monterey	3,108	3.4	33[a]	2,381	77	369	12	138	4	37	1
Napa	670	2.7	38	548	82	75	11	36	5	3	0.4
Nevada	1,011	6.2	19[a]	863	85	133	13	15	1	2	0.2
Orange	17,346	3.1	36[a]	12,888	74	3,153	18	819	5	34	0.2
Placer	1,170	3.2	35[a]	971	83	125	11	51	4	11	1
Plumas	381	7.6	11[a]	256	67	38	10	6	2	1	0.3
Riverside	13,629	6.3	18[a]	10,475	77	2,111	15	583	4	7	0.05
Sacramento	14,919	6.4	17[a]	12,521	84	1,201	8	492	3	45	0.3
San Benito	251	2.6	39	127	51	39	16	23	9	2	1
San Bernardino	15,796	5.1	26	13,519	86	1,172	7	713	5	29	0.2
San Diego	32,577	6.2	19[a]	28,103	86	2,171	7	1,734	5	54	0.2
San Francisco	3,939	3.2	35[a]	1,892	48	1,164	30	347	9	120	3
San Joaquin	5,120	4.4	30[a]	4,178	82	437	9	195	4	32	0.6
San Luis Obispo	2,296	5.9	20[a]	2,071	90	121	5	54	2	12	0.5
San Mateo	5,027	3.5	32	4,426	88	219	4	243	5	8	0.2
Santa Barbara	3,609	4.6	29	3,240	90	207	6	121	3	12	0.3
Santa Clara	16,698	4.4	30[a]	13,966	84	1,305	8	249	1	28	0.2
Santa Cruz	1,209	2.5	40	829	69	213	18	100	8	3	0.2
Shasta	2,796	7.7	10	1,993	71	289	10	131	5	1	0.04
Sierra	58	7.2	14	13	22	19	33	8	14	0	0
Siskiyou	744	6.4	17[a]	637	86	48	6	13	2	0	0
Solano	3,548	4.4	30[a]	3,149	89	180	5	178	5	15	0.4
Sonoma	4,994	5.9	20[a]	3,983	80	545	11	37	0.7	4	0.08

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APPENDIX TABLE 10-3 Continued

County	No. of Inquiries	(%) Inquiry Rate	Inquiry Rank	Closed— No Action	(%) CNA Rate	To FM	(%) FM Rate	To Reun.	(%) Reun. Rate	To PP	(%) PP Rate
Stanislaus	5,540	6.3	18[a]	5,273	95	252	5	225	4	1	0.02
Sutter	1,505	9.1	5[a]	1,135	75	226	15	37	2	7	0.5
Tehama	1,026	8.6	7	591	58	74	7	35	3	0	0
Trinity	400	10.7	3	350	88	29	7	22	6	0	0
Tulare	6,969	7.9	9	5,149	74	303	4	494	7	12	0.2
Tuolumne	539	5.6	23	460	85	62	12	14	3	0	0
Ventura	5,185	2.8	37	4,566	88	220	4	226	4	19	0.4
Yolo	1,984	6.7	15	1,865	94	90	5	74	4	5	0.3
Yuba	2,127	13.1	2	1,870	88	218	10	43	2	2	0.1

Note: Rates are per 100 children in county; ranks = 1–42; CNA = closed, no action; FM = Family Maintenance (program); Reun. = Reunited with family; PP = Permanent placement.

[a] Two or more counties share the same rank.

SOURCE: State of California Department of Social Services 1986

APPENDIX TABLE 10-4 Rate and Rank of Emergency Response Services Provided, January–December 1986, by County, in California

County	General Neglect		Physical Abuse		Sexual Abuse		Abandonment/ Incapacity		Emotional Abuse	
	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
Alameda	8.5	50	10.5	40	6.6	36	7.0	21	0.2	33
Alpine	16.3	35	0	54	9.8	23	19.6	1	0	36
Amador	10.6	44	8.3	45	2.8	47[a]	4.3	34	1.0	25
Butte	32.0	12	16.5	14	18.6	5	18.8	3	2.8	13[a]
Calaveras	26.0	21	12.9	31	9.5	24[a]	7.4	18	3.7	8
Colusa	37.6	7[a]	15.5	17	9.1	26[a]	6.1	24	1.7	19[a]
Contra Costa	15.7	36	11.7	35[a]	6.9	35	4.2	35	1.2	23[a]
Del Norte	69.2	1	28.8	2	21.2	2	10.1	10	6.5	4
El Dorado	9.5	47	7.3	47	5.9	38	8.1	14	1.1	24
Fresno	37.6	7[a]	27.3	3	15.7	8	2.8	39	0.3	32[a]
Glenn	29.7	15[a]	4.9	52	3.1	46	3.6	37[a]	5.5	7
Humboldt	27.0	20	14.2	24[a]	8.5	28	5.3	28	2.2	17[a]
Imperial	13.3	40	4.3	53	2.3	48	1.6	46	0.5	30[a]
Inyo	19.2	30	13.0	30[a]	20.0	3	0.6	49	0.9	26[a]
Kern	27.9	17	22.6	5	8.0	30	4.9	31	0.5	30[a]
Kings	19.9	28	13.0	30a	6.1	37[a]	2.7	40[a]	1.5	20a
Lake	42.7	4	13.4	29	5.2	40[a]	11.0	9	1.7	19[a]
Lassen	27.5	19	11.8	34	7.0	34[a]	5.9	25[a]	2.4	15[a]
Los Angeles	12.7	41	15.1	18	8.1	29	3.6	37[a]	1.5	20[a]
Madera	16.9	34	10.8	39	7.5	31	7.1	20[a]	0.7	28[a]
Marin	5.4	53[a]	5.3	51	2.8	47[a]	2.6	41	0.8	27[a]
Mariposa	32.2	11	11.7	35[a]	12.1	13	5.4	27	5.7	6
Mendocino	31.9	13	14.6	22	14.8	9	8.9	12	0.8	27[a]
Merced	25.9	22	19.7	7	19.5	4	9.9	11	2.7	14
Modoc	30.1	14	18.1	11	9.4	25	18.9	2	5.8	5
Mono	22.5	25	5.5	50	12.0	14	5.1	29	2.3	16

(APPENDIX TABLE 10-4 continued on next page)

APPENDIX TABLE 10-4 Continued

County	General Neglect Rate	General Neglect Rank	Physical Abuse Rate	Physical Abuse Rank	Sexual Abuse Rate	Sexual Abuse Rank	Incapacity Rate	Incapacity Rank	Emotional Abuse Rate	Emotional Abuse Rank
Monterey	12.6	42[a]	10.1	43	7.1	33	2.0	44	0.9	26[a]
Napa	8.8	49	10.2	42	5.2	40[a]	1.7	45	0.3	32[a]
Nevada	18.4	32	16.0	16	13.1	10	8.8	13[a]	3.6	9
Orange	6.4	52	14.2	24[a]	5.7	39	0.8	48	0.5	30[a]
Placer	14.0	39	6.7	48	3.2	45	2.7	40[a]	2.2	17[a]
Plumas	27.6	18	11.0	37[a]	10.0	22[a]	14.0	8	6.6	3
Riverside	22.3	26	16.2	15	10.1	21[a]	5.5	26[a]	1.8	18[a]
Sacramento	32.4	10	12.5	32	7.0	34[a]	6.3	23	2.4	15[a]
San Benito	3.9	54	7.8	46	4.1	43	5.5	26[a]	1.3	22[a]
San Bernardino	17.3	33	14.8	20	10.1	21[a]	3.3	38	0.5	30[a]
San Diego	20.7	27	18.7	10	10.3	20	8.8	13[a]	3.2	11
San Francisco	11.1	43	11.5	36	3.6	44	0.02	51	0.02	35
San Joaquin	12.6	42[a]	14.1	25	11.5	16	4.5	32	0.7	28[a]
San Luis Obispo	24.6	23	14.0	26	11.0	19	2.5	42	0.7	28[a]
San Mateo	10.2	45	10.9	38	6.1	37[a]	5.0	30	0.7	28[a]
Santa Barbara	15.6	37	11.0	37[a]	6.1	37[a]	7.2	19	3.0	12
Santa Clara	9.0	48	12.3	33	8.8	27	6.6	22	1.3	22[a]
Santa Cruz	6.7	51	5.7	49	4.9	41	4.4	33	0.4	31
Shasta	29.7	15[a]	18.8	9	16.3	7	7.1	20[a]	1.8	18[a]
Sierra	14.9	38	13.7	28	11.2	17[a]	18.6	4	7.5	2
Siskiyou	35.8	9	10.4	41	10.0	22[a]	14.8	7	1.5	20[a]
Solano	5.4	53[a]	13.9	27	9.5	24[a]	5.9	25[a]	1.4	21
Sonoma	23.0	24	19.1	8	11.2	17[a]	0.06	50	2.4	15[a]
Stanislaus	19.3	29	21.6	6	12.9	11	3.9	36	0.07	34
Sutter	41.0	6	17.4	12	11.6	15	16.4	5	2.8	13[a]
Tehama	41.2	5	14.3	23	18.0	6	8.0	15	2.8	13[a]
Trinity	36.8	8	22.9	4	12.8	12	14.9	6	12.3	1

(APPENDIX TABLE 10-4 continued on next page)

APPENDIX TABLE 10-4 Continued

County	General Neglect Rate	General Neglect Rank	Physical Abuse Rate	Physical Abuse Rank	Sexual Abuse Rate	Sexual Abuse Rank	Incapacity Rate	Incapacity Rank	Emotional Abuse Rate	Emotional Abuse Rank
Tulare	43.6	3	14.7	21	11.1	18	2.4	43	1.8	18[a]
Tuolumne	18.6	31	15.0	19	7.2	32	7.6	17	3.4	10
Ventura	10.0	46	8.6	44	4.3	42	0.9	47	0.6	29
Yolo	28.7	16	16.6	13	9.1	26[a]	8.8	13[a]	1.2	23[a]
Yuba	56.5	2	33.0	1	28.7	1	7.8	16	1.7	19[a]
Rank	1–54		1–54		1–48		1–51		1–36	
Rate range	69.2–3.9		33.0–0		28.7–2.3		19.6–0.02		12.3–0	

[a] Two or more counties share the same rank.

Note: Rates are per 1,000 children in county.

SOURCE: State of California Department of Social Services 1986.

APPENDIX TABLE 10-5 Reason for Emergency Response Service, January–December 1986, by County, in California

	Total No.	General Neglect No.	General Neglect %	Physical Abuse No.	Physical Abuse %	Sexual Abuse No.	Sexual Abuse %	Abandonment/ Incapacity No.	Abandonment/ Incapacity %	Emotional Abuse No.	Emotional Abuse %
Total	342,001	110,159	32	101,611	30	58,458	17	30,791	9	9,515	3
Alameda	10,035	2,508	25	3,098	31	1,937	19	2,078	21	51	0.5
Alpine	17	5	29	0	0	3	18	6	35	0	0
Amador	160	54	34	42	26	14	9	22	14	5	3
Butte	3,302	1,170	35	604	18	682	21	688	21	104	3
Calaveras	399	162	41	80	20	59	15	46	12	23	6
Colusa	304	153	50	63	21	37	12	25	8	7	2
Contra Costa	7,822	3,030	39	2,260	29	1,339	17	805	10	225	3
Del Norte	746	362	49	151	20	111	15	53	7	34	5
El Dorado	852	242	28	186	22	149	17	205	24	27	3
Fresno	15,879	6,327	40	4,601	29	2,649	17	473	3	56	0.4
Glenn	353	199	56	33	9	21	6	24	7	37	10
Humboldt	1,649	758	46	399	24	238	14	150	9	63	4
Imperial	832	474	57	154	19	81	10	56	7	17	2
Inyo	263	90	34	61	23	94	36	3	1	4	2
Kern	9,359	3,985	43	3,220	34	1,142	12	700	7	72	0.8
Kings	1,293	541	42	354	27	167	13	73	6	42	3
Lake	783	424	54	133	17	52	7	109	14	17	2
Lassen	383	181	47	78	20	46	12	39	10	16	4
Los Angeles	103,116	27,355	27	32,460	31	17,421	17	7,665	7	3,224	3
Madera	1,114	402	36	258	23	178	16	170	15	16	1
Marin	920	273	30	270	29	140	15	130	14	38	4
Mariposa	224	96	43	35	16	36	16	16	7	17	8
Mendocino	1,479	643	43	294	20	299	20	180	12	17	1
Merced	4,116	1,277	31	973	24	963	23	491	12	134	3
Modoc	244	83	34	50	20	26	11	52	21	16	7
Mono	103	49	48	12	12	26	25	11	11	5	5
Monterey	3,108	1,144	37	917	30	645	21	181	6	84	3
Napa	670	219	33	253	38	128	19	42	6	7	1
Nevada	1,006	301	30	261	26	214	21	144	14	59	6
Orange	17,295	3,602	21	7,986	46	3,210	19	442	3	279	2
Placer	1,170	515	44	247	21	118	10	99	8	80	7
Plumas	381	138	36	55	14	50	13	70	18	33	9
Riverside	13,709	4,804	35	3,497	26	2,168	16	1,191	9	393	3
Sacramento	14,932	7,515	50	2,896	19	1,619	11	1,453	10	560	4

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APPENDIX TABLE 10-5 Continued

	Total	Neglect		Abuse		Abuse		Incapacity		Abuse	
	No.	No.	%	No.	%	No.	%	No.	%	No.	%
San Benito	251	37	15	75	30	39	16	53	21	12	5
San Bernardino	15,647	5,379	34	4,614	29	3,134	20	1,043	7	48	0.9
San Diego	33,954	10,971	32	9,904	29	5,441	16	4,637	14	1,708	5
San Francisco	3,939	1,359	35	1,408	36	441	11	3	0.08	2	0.05
San Joaquin	5,165	1,455	28	1,632	32	1,327	26	520	10	80	2
San Luis Obispo	2,296	960	42	548	24	431	19	97	4	29	1
San Mateo	4,973	1,462	29	1,568	32	880	18	717	14	104	2
Santa Barbara	3,614	1,225	34	865	24	477	13	568	16	238	7
Santa Clara	15,695	3,406	22	4,679	30	3,358	21	2,507	16	509	3
Santa Cruz	1,209	330	27	283	23	242	20	216	18	20	2
Shasta	2,796	1,079	39	685	24	592	21	257	9	64	2
Sierra	58	12	21	11	19	9	16	15	26	6	10
Siskiyou	932	416	45	121	13	112	12	172	18	17	2
Solano	3,560	434	12	1,121	31	766	22	479	13	116	3
Sonoma	4,994	1,960	39	1,629	33	951	19	5	0.1	202	4
Stanislaus	5,570	1,701	31	1,895	34	1,136	20	345	6	6	0.1
Sutter	1,525	678	44	288	19	192	13	271	18	47	3
Tehama	1,062	494	47	172	16	216	20	96	9	34	3
Trinity	400	138	35	86	22	48	12	56	14	46	12
Tulare	6,969	3,867	55	1,303	19	981	14	214	3	162	2
Tuolumne	539	179	33	145	27	69	13	73	14	33	6
Ventura	4,693	1,770	38	1,572	33	790	17	168	4	107	2
Yolo	1,984	849	43	491	25	268	14	261	13	36	2
Yuba	2,158	917	42	535	25	466	22	126	6	27	1

SOURCE: State of California Department of Social Services (1986).

APPENDIX TABLE 11-1 Characteristics of the California Youth Authority Institutional Population (CYA CDC Cases), 1975–1987

	1975	1980	1983	1984	1985	1987	Percent Change 1975–1987
Total	4,449	5,043	5,757	5,700	6,474	8,385	88.5%
Sex							
Male	95.0	96.3	95.6	95.4	95.5	95.8	0.8
Female	5.0	3.7	4.4	4.6	4.5	4.2	–16.0
Court							
Juvenile	51.6	56.4	67.2	74.0	66.5	71.6	38.8
Criminal	48.4	43.6	32.8	26.0	18.4	11.7	–75.8
Criminal (M)					15.0	16.7	
Area/County							
Region I	18.9	20.4	18.3	18.1	18.6	24.2	28.0
Region II	17.2	17.3	18.4	17.8	19.4	18.8	9.3
Region III	36.9	44.6	48.2	49.5	47.3	38.1	3.3
Region IV	27.0	17.7	15.1	14.6	14.7	18.9	–30.0
Committed offense							
Violent	48.6	57.0	55.8	54.0	51.2	47.3	-2.7
Property	34.1	37.6	36.6	36.8	37.9	37.1	8.8
Narcotics and drug	5.5	1.8	3.0	4.4	4.7	9.7	76.4
Other	11.8	3.6	4.6	5.0	6.2	5.9	–50.0
Adm. status							
1st commitment	72.2	83.5	78.9	77.9	80.4	81.1	12.3
1st return	17.4	13.7	17.4	17.8	15.7	14.6	–16.1
2nd or more	10.5	2.9	3.7	4.4	3.9	4.3	–59.0
Ethnic status							
White	39.6	32.6	28.0	26.4	27.5	27.0	–31.8
Hispanic	21.2	30.1	31.7	32.6	31.7	31.3	47.6
Black	36.5	35.0	38.1	38.6	37.9	38.0	4.1
Other	1.7	2.2	2.2	2.5	2.9	3.7	117.6
YOPB status							
Full board	35.2	55.0	54.9	54.1	14.1	11.5	–67.3
Not full board	64.8	45.0	45.1	45.9	85.9	88.5	36.6
Mean Age (Years)	18.9	18.6	18.7	18.7	18.8	19.1	1.1

SOURCE: State of California, Department of the Youth Authority.

APPENDIX TABLE 11-2 Characteristics of the California Youth Authority Parole Population, 1975–1987

	1975	1980	1983	1984	1985	1987	Percent Change 1975–1987
Total	8,101	6,728	6,868	6,661	6,188	4,060	–49.9%
Sex							
Male	89.3	95.2	95.6	95.5	94.8	93.2	4.4
Female	10.7	4.8	4.4	4.5	5.2	6.8	–36.4
Court							
Juvenile	50.2	55.6	54.1	57.1	62.0	68.1	35.7
Criminal	49.8	44.4	45.9	42.9	38.0	31.9	–35.9
Area/County							
Region I	21.7	25.4	24.3	23.9	23.4	23.0	6.0
Region II	20.3	20.1	19.6	21.7	21.4	23.1	13.8
Region III	29.7	34.6	39.2	39.3	40.7	39.1	31.6
Region IV	28.3	19.9	16.9	15.1	14.5	14.8	–47.7
Committed offense							
Violent	31.7	45.3	49.6	49.3	48.6	43.8	38.2
Property	38.4	47.9	44.8	44.2	43.4	44.1	14.8
Narcotics and drug	10.6	2.7	2.2	2.7	3.8	6.2	–41.5
Other offense	19.3	4.1	3.4	3.8	4.0	5.9	–69.4
Adm. status							
1st parole	69.1	79.4	82.3	79.5	77.6	75.0	8.5
2nd parold	19.1	16.4	15.0	17.2	18.8	20.3	6.3
3rd or more	11.8	4.3	2.7	3.2	3.7	4.7	–60.2
Ethnic status							
White	47.8	36.9	34.1	32.3	31.2	32.5	–32.0
Hispanic	18.7	26.5	27.7	28.5	29.1	32.5	73.8
Black	30.8	33.9	35.4	35.9	37.0	31.2	1.3
Other	2.5	2.7	2.8	2.7	2.7	3.8	52.0
FB/SS status							
Full board	4.8	35.1	48.6	48.2	7.6	7.1	47.9
Not full board	73.7	53.7	51.1	51.8	92.4	92.9	26.1
Mean age (years)	20.4	20.1	20.4	20.6	20.6	20.7	1.5

SOURCES: State of California, Department of the Youth Authority.

APPENDIX TABLE 11-3 Characteristics of Male in Youth Authority Schools and Camps, 1975–1987

	1975	1980	1983	1984	1985	1987	Percent Change 1975–1987
Total	3,717	4,316	4,775	4,905	5,489	7,005	88.5
Court							
Juvenile	50.0	55.8	66.0	74.1	67.0	71.3	42.6
Criminal	50.0	44.2	34.0	25.9	19.5	11.6	–76.8
Criminal (M)					13.5	17.1	
Area/County							
Region I	18.3	20.2	17.1	18.0	18.2	18.8	2.7
Region II	16.6	17.1	17.9	17.4	18.7	21.4	28.9
Region III	37.7	44.5	49.4	49.7	48.6	45.9	21.8
Region IV	27.4	18.2	15.6	14.9	14.5	13.9	–49.3
Committed offense							
Violent	50.1	57.4	57.3	54.7	54.7	48.0	–4.2
Property	34.5	37.5	35.8	36.7	37.4	36.9	7.0
Narcotics and drug	5.5	1.7	2.6	4.0	4.4	9.4	70.9
Other offense	10.0	3.4	4.3	4.8	5.9	5.7	–43.0
Adm. status							
1st commitment	71.3	82.1	79.1	77.9	78.6	80.1	12.3
1st return	17.8	14.8	17.4	18.0	17.2	15.4	–13.5
2nd or more	11.0	3.0	3.5	4.1	4.2	4.5	–59.1
Ethnic status							
White	38.4	32.6	26.9	25.3	25.7	26.6	–30.7
Hispanic	21.8	30.1	32.4	33.1	32.4	31.2	43.1
Black	37.2	35.0	38.7	39.2	38.9	38.5	3.5
Other	2.6	2.3	2.0	2.4	3.0	3.7	42.3
YOPB status							
Full board	38.6	55.0	58.1	56.4	15.0	12.1	–68.7
Not full board	61.4	45.0	41.9	43.6	85.0	87.9	43.2
Mean age (years)	19.0	18.6	18.8	18.7	19.0	19.3	1.6

SOURCE: State of California, Department of the Youth Authority.

APPENDIX TABLE 11-4 Comparison of Four Probation Subsamples, Youth Authority First Commitments

Background Variable	Private Placement	Juvenile Hall Commitments	Camp Wards	YA 1st Commitments	Significant Difference
Sample Size	1,503	404	206	3,774	1,021
Sex					
Male	85.8%	79.9%	93.7%	93.0%	82.6%
Female	14.2	20.3	6.3	7.0	17.4
Ethnicity					
White	46.8	52.5	42.2	34.0	24.3
Hispanic	27.8	19.6	33.0	31.8	31.3
Black	21.8	25.2	20.9	31.2	40.9
Other	3.6	2.7	3.9	3.0	3.5
Age					
Under 12	1.0	2.5	0.5	0.3	0.0
12–13	11.8	16.9	3.9	4.9	1.3
14–15	35.5	45.2	24.3	33.6	23.4
16–17	48.5	35.0	60.1	58.0	68.4
18–19	3.1	0.2	11.2	3.1	6.9
Average	15.4	14.8	16.1	15.7	16.2
Offense category					
Person	17.8	20.8	14.6	25.5	
Property	55.9	60.0	41.2	52.2	
Other	26.3	19.2	44.2	22.3	
Offense type					
Homicide/Manslaughter	0.3	0.0	0.5	0.2	8.3
Robbery	3.7	3.2	1.5	10.1	23.4
Assault	13.1	15.0	11.6	13.9	21.4
Forcible rape	0.3	0.5	0.5	0.7	3.9
Kidnapping	0.2	0.5	0.0	0.2	1.6
Arson	0.3	1.5	0.5	0.4	0.1
Burglary	24.4	25.7	14.1	27.6	16.0
Theft/Forgery	16.1	15.3	13.6	16.2	11.5
Petty theft	11.2	15.7	9.2	6.5	0.6
Other sexual offenses	3.3	6.0	1.5	1.8	1.2
Drug/Narcotics	1.7	0.8	4.4	2.4	3.6
Other drug	2.6	2.7	4.9	4.5	1.9
Marijuana	4.5	1.0	5.8	3.0	1.6
Miscellaneous felony	2.0	1.5	1.5	2.4	1.6
Miscellaneous property	4.2	3.3	4.4	1.9	0.4
Miscellaneous misdemeanor	5.8	4.3	6.3	3.7	0.6
Traffic/Drunk driving	4.8	0.2	3.9	0.9	0.2
Prob. Violence	0.8	1.5	7.8	2.0	0.3
Escape	0.9	1.2	8.3	1.5	2.0
Offense Seriousness					
Low	15.6	10.0	23.3	8.7	1.4
Medium	72.9	76.5	66.5	70.4	43.0
High	11.5	13.5	10.2	20.9	55.6
Age at first referral					
Under 9	0.3	1.0	1.0	0.8	1.3
9–10	2.2	4.5	3.4	3.7	2.7
11–12	10.5	22.1	15.5	14.3	16.2
13–14	33.6	43.9	34.9	43.0	41.6
15–16	39.4	27.0	37.9	32.1	34.7
17–18	14.0	1.5	7.3	6.1	3.4
Average	14.5	13.4	14.0	13.9	13.8

(APPENDIX TABLE 11-4 continued on next page)

APPENDIX TABLE 11-4 Continued

Background Variable	Private Placement	Juvenile Hall Commitments	Camp Wards	YA 1st Commitments	Significant Difference
Average Time from first Referral to current status	0.9	1.4	2.1	1.9	2.4
Prior Sustained Petitions					
0	66.7	53.2	22.8	29.3	17.7
1 18.4	25.5	32.5	29.7	16.4	
2	8.1	13.9	15.5	22.0	19.4
3	4.0	4.0	10.7	10.8	16.5
4 or more	2.9	3.5	18.4	8.2	30.3
Average number of priors					
All youth	0.6	0.8	1.9	1.4	2.7
Youth with priors	1.8	1.7	2.4	2.1	3.0
Type of Offenses Among Total Prior for Entire Sample					
Homicide/Manslaughter	0.0	0.0	0.0	< 0.1	0.1
Robbery	1.7	2.5	2.6	4.9	5.2
Assault	9.2	10.3	9.8	9.7	11.8
Forcible rape	0.2	0.0	0.0	0.2	0.3
Kidnapping	0.3	0.3	0.3	0.1	0.3
Arson	0.4	1.2	0.3	0.5	0.6
Burglary	21.9	25.9	22.2	26.3	22.4
Theft/Forgery	16.6	14.4	15.8	17.8	17.2
Petty theft	12.7	17.8	15.6	12.4	9.7
Other sexual offenses	1.1	1.2	1.6	0.8	1.1
Drug/narcotics	0.6	0.0	1.3	1.3	1.0
Other drug	2.7	3.1	5.0	3.8	2.8
Marijuana	2.9	1.9	4.0	3.3	1.7
Miscellaneous felony	1.7	0.9	1.6	1.9	1.3
Miscellaneous property crimes	6.9	6.9	4.7	4.1	3.9
Miscellaneous misdemeanor	8.8	9.7	8.7	6.7	5.4
Traffic/Drunk driving	2.0	0.0	1.3	1.3	0.6
Prob. violence	7.9	1.2	1.8	3.5	9.8
Escape	2.6	2.5	3.4	1.5	4.6

SOURCE: State of California, Department of the Youth Authority.